The Lived Experience of Aging Black Women with Diabetes Nurse-Person Relationships

Deidra G. Brown

City University of New York, Graduate Center

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The Lived Experience of Aging Black Women with Diabetes Nurse-Person Relationships

by

Deidra G. Brown

A dissertation submitted to the Graduate Faculty in Nursing Science in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York

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This manuscript has been read and accepted for the Graduate Faculty in Nursing in satisfaction of the dissertation requirement for the degree of Doctor of Philosophy.

Dr. Donna M. Nickitas

Date

Chair of Examining Committee

Dr. Donna M. Nickitas

Date

Executive Officer

Dr. Steven L. Baumann

Dr. Nicole Hollingsworth

Dr. Barbara Gail Montero

Dr. Martha V. Whetsell

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK
Abstract

THE LIVED EXPERIENCE OF AGING BLACK WOMEN WITH DIABETES NURSE-PERSON RELATIONSHIPS

by

Deidra G. Brown, RN, MSN, GNP-BC

Adviser: Dr. Donna M. Nickitas

The lived experience of the nurse-person relationship may have meaning for Black women with diabetes as they grow older. However, insufficient nursing research has been conducted in this area. This hermeneutic phenomenological study was designed to provide insight into the experiences of older Black women with diabetes as they transition through the aging process and to elucidate their perceptions of the nurse-person relationship. In-depth semi-structured interviews were conducted to explore the lived experience and perceptions of these women, and data was collected for developing a deeper understanding of this phenomenon. The method used to conduct this research was Max van Manen’s hermeneutic phenomenology. Nine Black women diagnosed with diabetes between 4 and 38 years were interviewed. The meaning of the lived experiences of aging with diabetes and being cared for by nurses in their homes uncovered four essential themes that culminated into a thematic statement that elucidated the participant’s stories: Being in the moment with another in authentic presence; while dwelling and creating opportunities to achieve wellness by transcending suffering and illness through love and compassion in a human-to-human connection. Halldorsdottir (2012) Nursing as Compassionate Competence Theory was reflected upon to illuminate the persons’ perception of lived experience of nursing care in view of the dynamics of the nurse-person relationship.

Key Words: Black women, nurses, nurse-person, relationship, diabetes
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CHAPTER I

Aim of the Study

“We all live in the hope that we’ll remain safe and comfortable as we approach the age when dependence on others can become inevitable. But all around the world we see countless numbers of elderly people who continue to work in labor intensive jobs many years after they should have retired. Millions of men and women face a future without adequate benefits, companionship or support, all because there is no one to look after them.”—The Dignity Project (2013)

The indefinite duration of working years and the general perception of aging as being on par with chronic disease suggest that older individuals are often alone and lack necessary care. This situation is reality for elderly individuals who retire later in life and have inadequate resources, including insufficient care and support. Therefore, examining elder adults’ experiences is critical to understanding their needs for support and care. Within the context of support for elderly individuals with chronic disease, this phenomenological research study seeks to uncover and understand the meanings and essences of the lived experiences of elderly Black American women (BW) with diabetes. To meet their needs, it is important to gain insight into how they perceive their relationships with nurses and the meaning that the experience holds for them. Life expectancy at birth, especially for women, is longer as compared with 20 years ago. For people born in 2008, overall life expectancy was 78.1 years. From 1995 to 2015, life expectancy increased for females (80.4 to 80.6) and for the Black population (73.6 to 74.0) (National Institute on Aging [NIA], 2012). As individuals live longer, however, they face rising health care costs and decreased resources for managing chronic diseases.

In addition, with longer life expectancy, more people are living with chronic diseases. For example, over 10 million Americans have diabetes, including 26.9% of all people 65 years and older, and about 12.65% of people with diabetes are Black Americans (BA) (National Diabetes
Information Clearinghouse, 2011). The effects of aging alter the health patterns of older people, and these changes add to the burden of living with a chronic disease (Giddings, Roy, & Predeger, 2007). Further, physiologic changes normally occur with aging. Chronic disease may contribute to reductions in health, function, social status, and also tax economic resources (Deshpande, Harris-Hayes, & Schootman, 2008; Forti, Johnson, & Graber, 2000).

Living with chronic disease and consequent disability is challenging for many older Americans (Hughes, Woodward, & Velez-Ortiz, 2013). Impaired functional status compromises the ability of older people to independently perform routine daily activities. Loss of independence may limit social contact and access to care and resources, increasing the risk that older people with a chronic disease will experience impaired health (Druss et al., 2009; Giddings, Roy, & Predeger, 2007; Schwartz et al., 2002).

The incidence and prevalence of chronic and debilitating conditions increase as the number of elderly people increases (National Academy on an Aging Society [NAAS], 1999). This is especially true for older BW, who are affected more by the long-term complications of aging and disease as a result of increased longevity (Golden et al., 2012). Currently, BA have higher rates of chronic illness such as Type 2 diabetes as compared to White Americans (Olshansky, Goldman, Zheng, & Rowe, 2009). Many BA are living longer with chronic diseases, including diabetes (Schoenberg & Drungle, 2001).

Understanding the experiences of older BW living and aging with diabetes is critical to offering appropriate care. Nurses need to have insight about the changes these women face in later life that affect their well-being. Older women with diabetes manage the daily realities of their disease on their own and often receive only episodic intervention from health care providers (Schoenberg & Drungle, 2001). For many older BW, this situation means engaging in complex
medical regimens that may become too difficult to manage (Tanner, 2004). This study explored aging BW with diabetes and their perceptions of how nurses cared for them, and it also investigates how their lives were changed by nursing care provided with compassionate competence. The purpose of this phenomenological study is to provide insight into the nurse-person relationship for BW aging with diabetes.

**The Phenomenon of Interest**

Professional nurses provide care to individuals with diverse conditions, including acute, chronic, rehabilitative, and palliative/hospice care and management, across their life span. This study focuses on the experiences of elderly BW aging with diabetes, a chronic disease. This study is an examination of the lived experience of these women, how they perceive their relationship with their nurses, and the meaning the experience holds for them. Knowing about the meaning of aging with diabetes for BW may provide insights in the context of nursing, including how to better address the women’s health problems and needs and provide support. This study may also reveal how improved care coordination reduces costs and burdens within this population.

**Research Question**

What is the lived experience of aging black women with diabetes perceptions of the nurse-person relationship?

The phenomenological design of van Manen’s (1997) interpretative method was used to explore this phenomenon. Through an exploration of the experiences of elderly BW and their perceptions of the relationship with nurses, a clearer understanding of the underlying processes emerged.
**Justification for the Study**

Women are living longer with diabetes; therefore, the time during which the disease may affect their lives is extended (Golden et al., 2012). To date most studies in nursing have examined older women with diabetes within the context of treatment adherence and self-management (Meneilly, Knip, & Tessier, 2013; Montague, Nichols, & Dutta, 2005). This study focuses on uncovering the patterns and processes in lives of aging black women with diabetes and how they perceive the relationship with their nurses, and the meaning the experience holds for them. Understanding this phenomenon is important in developing nursing knowledge as well as addressing health care delivery and controlling the costs of care for chronic disease management.

Several provisions in the Affordable Care Act of 2010 highlight the importance and consequences of chronic diseases, such as diabetes, on individual health and on health care costs and expenditures (NIA, 2012). One such provision describes Accountable Care Organizations, which are designed to use more efficient collaborative models to improve the quality of care and reduce costs. In addition, transition programs are designed to coordinate care after hospital stays and connect patients to appropriate resources, with the goal of reducing unnecessary readmissions (Naylor et al., 2009). Gaps in Medicare prescription drug coverage are being reduced to make medications more affordable for seniors (NIA, 2012). Incentives to develop the primary care work force have also been enacted to increase access to affordable care for all Americans (NIA, 2012). In general, these health policies focus on interventions to better manage health of individuals with chronic diseases and improve morbidity and mortality rates (Olshansky et al., 2009). This nursing research study may reveal new ways to organize and deliver care to enhance the lives of older BW women living with diabetes.
Declining functional abilities and diminished control of everyday activities may force BW aging with diabetes to change their lifestyles. Understanding the individual needs of these older women is essential to ensuring appropriate nursing care. This understanding may also provide opportunities to deliver appropriate, meaningful, and effective care with a coordinated approach (Owens et al., 2008).

This phenomenological study explores all aspects of the lives of BW with diabetes to elucidate their experiences and their perceptions of the nurse-person relationship. Reflection on this experience raises the question “What is it like for these women being in the world?” Which leads to the following questions: “How does aging impact living with diabetes?” and “What have been the women’s experiences with nurses?” The aging BW with diabetes offers a unique opportunity to explore living with a chronic disease. This study uncovers the meaning of living with diabetes for aging BW and the enduring changes influenced by the nurse-person relationship during this major life transition.

**Phenomenon Discussed Within Specific Content**

Among elderly BW with diabetes, complications of the disease are a major cause of death and disability (Agency for Healthcare Research and Quality [AHRQ], 2008; American Diabetes Association [ADA], 2011; Centers for Disease Control and Prevention [CDC], 2011; Deshpande et al., 2008; U.S. Census Bureau, 2010). In general, functional decline ensues as individuals with diabetes age because they are more predisposed to complications of the disease, including peripheral neuropathy, visual impairments, and cardiac and renal disease (Deshpande et al., 2008). The effects of diabetes are different for older individuals compared with younger people, symptoms may be masked, and tighter control is required; in addition, older individuals’ response to medications may differ from what is expected (Nicholas, Nadeau, & Johnson, 2009).
Fundamental and challenging lifestyle changes must be made to minimize complications, slow the progression of the disease, and improve health outcomes (Adili, Higgins, & Koch, 2010).

Lifestyle changes for elderly BW with diabetes may not simply rest on the performance of particular tasks. Health decisions will be made based on their life experiences and knowledge base, and lifestyle changes may encompass everything within the social context of their lives (Whittemore & Roy, 2002). How lifestyle adjustments are made by elderly BW with diabetes is important to their current and future health, and an exploration of their personal stories for a better understanding of the challenges that confront women aging with diabetes is essential. The contexts of this study are the personal experiences of elderly BW living with diabetes as well as their perceptions of their relationships with nurses. Drawing on the personal experiences of these women may greatly enhance the understanding of how care coordination may be designed to better serve this population.

To effectively coordinate nursing care for elderly BW and other populations, understanding what is meaningful to individuals living with the disease is important (Borglin, Edberg, & Hallberg, 2005). As women with diabetes become older, the ways that the disease affects them may change. They may experience sensory problems and impaired functional status, and these factors may be influenced by past personal experiences as well as by socioeconomic factors. Exploring the meaning older women ascribe to their experiences is important in understanding how they cope with diabetes in their later years (National Research Council [NRC], 2006a). Understanding the meaning of living with diabetes and perceptions of the nurse-person relationship may also help in developing individual and culturally appropriate models of care that address older women’s special needs and reduce the impact of aging with diabetes (Borglin, Edberg, & Hallberg, 2005).
Assumptions and Biases

I have witnessed the challenges encountered by BW aging with diabetes. These challenges are often associated with dependency that diminishes all aspects of their health in their later years. My assumption is that the effects of aging impact the lives of elderly BW living with diabetes. Witnessing the difficulties individuals face in managing diabetes leads me, as a public health nurse, to ask what is required to improve nursing caring for those aging with the disease. Many of my interactions with older women with diabetes have focused on teaching specific tasks and assessing clinical outcomes. However, a deeper understanding of the lived experience of individual elderly women and their ways of being is essential to the development of caring science and more meaningful nurse–person situations (Chesla, 2005). I also assume that elderly women present an important context for exploring the effects of aging with diabetes. This exploration may illuminate challenges, meanings, and concerns relevant to aging diabetic BW. Older individuals are likely to be heterogeneous in many aspects (NRC, 2006b); therefore, the readiness and capacity to adapt to age-related changes while living with diabetes may vary. Additionally, socioeconomic and life circumstances may also differ. As a consequence, the women may experience impairments, despite their desire to remain in good health and manage their diabetes effectively. These presuppositions are derived from my professional experience and a review of the literature (Borglin et al., 2005; Golden et al., 2012; Tanner, 2004). This study seeks to understand the personal experiences of elderly BW with diabetes and their perceptions of the nurse–person relationship.

Methodology

The hermeneutic (interpretative) phenomenological method is based on an interpretation of participants’ linguistic descriptions of the phenomenon within the context of their “life
worlds” (Lopez & Willis, 2004). These descriptions illuminate the meanings of the individuals’ experiences and reveal how the context of their experiences influences these meanings and therefore affects the choices that they make (Lopez & Willis, 2004; Wojnar & Swanson, 2007). McManus-Holroyd (2007) stated that “The objective is to clarify conditions that can lead to understanding.” She further explained that this objective is achieved through the interpretation of the structures of the experiences, which is fostered by a linguistic link between the people who lived the experiences and the researcher (McManus-Holroyd, 2007). The focus of a hermeneutic inquiry is on what humans experience rather than what they consciously know (Lopez & Willis, 2004).

Hermeneutic phenomenology aims to reveal what is hidden within a person’s life experience in order to understand the essence of that experience and provide insight into what it means for the individual (Dahlberg, 2006). This method is most useful when the goal is to interpret human experiences within the social context of individuals’ daily lives. Another philosophical assumption underlying the hermeneutic phenomenological approach is that presuppositions or the researcher’s expert knowledge are valuable guides to making inquiries and supporting a meaningful undertaking (Lopez & Willis, 2004). According to van Manen (1990/1997), the phenomenological researcher should acknowledge what is known about the inquiry and hold their assumptions at bay, so that the essences of the phenomenon may emerge without biases.

**Relevance to Nursing**

The United States is transitioning toward an older, more ethnically and racially diverse population (NIA, 2012). Increased longevity in the population presents a host of challenges, affecting economic growth, formal and informal social support systems, and the provision of
resources for older people (NRC, 2006a). It is imperative to explore from a nursing perspective the challenges surrounding the growing burden of aging with a chronic disease in order to improve nursing and health care services to the diverse elderly population.

Older women living with chronic diseases have unique challenges that require exploration and understanding. Aging with a chronic disease may result in women feeling overwhelmed, alienated, and without a voice within the delivery of health care (Kralik, Koch, Price, & Howard, 2004). Greater understanding of the context in which older women live with a chronic disease is essential to elucidate their experiences of ageing as a biological, psychological, and social phenomenon. Nursing research on the topic of women aging with diabetes is important because how they view their lives may not be congruent with wider cultural beliefs of decline (Paulson & Willig, 2008).

Conducting nursing research is particularly important during the aging transition for elderly BW with diabetes because this transition involves significant changes in activity and health patterns (Chin, Polonsky, Thomas, & Nerney, 2000; NRC, 2006b). The purpose of this study is to contribute to nursing research, education, and practice based on the experiences of older women with diabetes as they transition through the aging process and clarify their perception of the nurse-person experience. Additionally, this study may contribute new knowledge by identifying changes in life patterns of older women with diabetes and thereby add to nursing education, practice, and research (Watson, 2009). Such information is increasingly important as more people in this society become aged, and the prevalence and complications of chronic diseases increase.
Summary

Chapter I presented the phenomenon of interest for this phenomenological study, which is to examine the lived experiences of elderly BW with diabetes. The challenges associated with aging with diabetes were discussed. Justification for the study, assumptions and biases, and relevance to nursing were illuminated. This study may provide insight into what aging is like for women living with a chronic disease. It may also guide nursing science in developing ways of understanding nurse-patient relationships and nursing care that improve the lives of BW aging with diabetes.
Chapter II

Evolution of the Study

Changes in longevity for the U.S. population as well as the increased incidence and prevalence of chronic disease have significantly impacted nursing education and practice, including the settings, populations, and methods for delivering nursing care (U.S. Department of Health and Human Services [USDHHS], 2006). Reflecting on the dignity project, many elderly individuals are living alone in community settings and require nursing care. The increasing need for nurses to care for the elderly living alone and at risk is due to several factors, including the shift from acute to community care, rising health care costs, and emerging models of care delivery (Institute of Medicine [IOM], 2010). These factors affect the intensity of nursing care as well as the caring interaction between the nurse and the individual (Watson, 2009). The lived experience of older people aging with a chronic disease and their perceptions of competent relationships with nurses has not been well studied. This study will explore the meaning and essence of aging BW’s lived experience with diabetes and shed light on their perceptions of competent relationships with nurses.

Historical Context

Blacks Aging in America

When considering how older BA are cared for and the issues of growing old in the past and present, it is important to understand the societal factors that influence aging and shape the experience of growing old (Thane, 2003). The experiences of aging and old age for BA are influenced by cultural beliefs and practices brought from Africa (Palmer, 2000). The effects of slavery and its sequelae have also influenced all aspects of BA life to the present day (Byrd & Clayton, 2000). These effects include multiple factors encompassing social, cultural, and economic disparities that influence the experience of aging for BA (Fett, 2002).
From the 16th to mid-19th century, the ancestors of most BA entered this country by forced exodus from Africa to serve as a source of free labor (Palmer, 2000). Elderly BA were leaders of the slave communities, loved and respected for their wisdom and position as religious teachers (Ruiz, 2004). Older slave women were especially held in high regard by younger generations (Byrd & Clayton, 2000). Religious guidance provided by older women kept the slave communities hopeful and alive, elevating their position in society (Byrd & Clayton, 2000). The position of older BW as leaders in their families and communities transcended the slave era (Ruiz, 2004). Older BW maintained their extended family networks and strong kinship values in the face of difficulties imposed by frequent separations and the constraints of bondage. The African people also brought and retained traditional medicine and healing practices (Byrd & Clayton, 2000). The older women provided a health subsystem for slaves. They were the primary caregivers of the sick and injured until BA were emancipated from the tyranny of slavery following the American Civil War (Byrd & Clayton, 2000; Fett, 2002).

Most Black Americans witnessed little change in their socioeconomic conditions after the war, however. In the 1890s, several thousand BA migrated to Kansas and Oklahoma to escape racism and establish independent communities (Bair, 2000). However, until the beginning of the 20th century, 90% of BA lived in the rural South, with the majority being tenant farmers and sharecroppers (Grossman, 2000; Hurt, 2003). Extended family and friend networks lived in close proximity and provided a support system, but in many ways their lives were not different from what they had been during the slavery period (Ruiz, 2004). Marginalized and living under racist political and economic systems, BA had little opportunity to improve their life conditions (Hurt, 2003).
Between 1910 and 1950, millions of BA left farms for better employment opportunities in cities. Urban life was usually limited to menial jobs, inferior schools, and segregated neighborhoods (Bair, 2000). During this period, BA maintained strong kinship networks that included both extended family and friends, and older people that needed help were cared for by family (Bair, 2000). Older BA often continued to work and provide needed assistance to the family unit (Ruiz, 2004).

Countless political outcries and BA activists resisted laws and practices that legitimized unequal treatment and acts of violence spawn by racism (Harding, Kelley, & Lewis, 2000). Living in a society that deprived them of civil rights and protection, BA developed independent institutions such as banks, churches, hospitals, newspapers, business, and schools to serve their communities and provide for their advancement (Bair, 2000). People gathered in churches, and the church family provided a strong extended family network for both spiritual and economic support as needed; they also cared for elderly members (Grossman, 2000).

Prior to World War II, approximately 70% of BA remained on southern farmlands (Harding et al., 2000). During and after World War II, BA continued to leave the farm life. This movement was due in part to modernization of farm equipment and the subsequent decreased need for human labor (Hurt, 2003). Also, opportunities for employment could be found in both southern and northern cities. World War II veterans returned home, awakened by the experience of fighting for their country, and they demanded social justice for BA (Harding et al., 2000). The political climate was right for change, and the U.S. image abroad was marred by the way BA citizens were treated (Harding et al., 2000). The federal government responded to demands of the Black American community for social justice and equal treatment by passing civil rights laws (Harding et al., 2000).
Having endured a long history of unequal treatment and social injustice, BA experienced aging in the context of racial/ethnic disparities in health and health outcomes (Byrd & Clayton, 2000; Kelley, 2000). These health disparities continue to exist and affect vulnerability to illness and disease (AHRQ, 2012). The disparities are more influenced by social determinants of health (SDH) than health care access and quality (Srinivasan & Williams, 2014; Braveman & Gottlieb, 2011). SDH are “the conditions in which people are born, grow, live, work, and age, they are determined by the distribution of money, power and resources” (World Health Organization [WHO], 2013).

Specific conditions of Black American family relationships and interactions also influence the experience of aging (Jewell, 2003). BA have maintained traditions of strong kinship ties and extended family networks, values that continue to prevail today (Palmer, 2000). BA have deep admiration and respect for their elders, and older BA play an important role in Black family and community life (Ruiz, 2004). Extended family support is prevalent in the care of older BA and stems from a sense of familial obligation (Boyd-Franklin, 2003; Dilworth-Anderson & Goodwin, 2006). The experience for most aging BA of being cared for is within the context of care given by adult children, particularly adult daughters (Jones et al., 2008).

**Aging in America**

Much of what is documented about the experience of aging focuses on men of European culture and background. From a social context, little is known about aging within minority populations and underrepresented groups. The social and cultural constructions of aging and the resources needed to address the challenges of aging must be understood. The social contexts in which people age may impact individual patterns of aging and how older people are cared for in ways that remain relatively unexplored (NRC, 2006b).
Many of the challenges that elderly individuals face are imposed by societal views of aging and old age (Angus & Reeve, 2006). How older people are viewed and their places in society have undergone radical changes throughout American history. During the first 200 years of this country’s history, large cohorts of people did not reach old age; those that did were generally respected (Fischer, 1978). During the preindustrial period, aging was viewed as a period of diminished control and increased dependency on the younger generation (Alter, 2013). Because property was passed from generation to generation, adult children were obligated to care for parents in order to receive their inheritance (Ruggles, 2003). Aging parents in poor health were usually cared for by unmarried children if any were available. If they had no unmarried children, ill parents lived with their married children. Poor people with no one to care for them lived in workhouses usually under substandard conditions (Thane, 2003). Elder care was less of an issue because only about half of people age 40 reached age 65, and half of those reached age 75 (Alter, 2013).

The percentage of older people in the population has continued to rise astronomically over the past two centuries, with life expectancy increasing to 78 years in 2010 (Murphy, Xu, & Kochanek, 2012). The modernization of the Western world has drastically changed societal views of old age as well as the lives of older people living in America (Olshansky et al., 2009). Modernization of society and increased longevity in turn influence how society views older adults. As modernization unfolded, technological advances provided jobs for people in urban environments, causing large numbers of Americans to leave rural communities (Ruggles, 2003). This shift from a rural to an urban economy led to smaller family units (Thane, 2005), and following the post–World War II “Baby Boom,” the size of American families began to shrink and the percentage of older people in the population began to increase (Olshansky et al., 2009).
The modern American family values independence and autonomy, and older individuals may strive to maintain independence even when support is needed (Thane, 2005). Additionally, many people that reach old age live longer with chronic diseases. As a result, many older individuals face living alone with a chronic disease, without needed support (US DHHS, 2011). Their challenges and health needs are best understood within the social context of individual lived experiences. Therefore, to provide the best possible care for older adults, nurses must explore aging from varied cultural, social, and ethnic perspectives to better understand the challenges and health needs of this population (Naylor et al., 2009).

**Experiential Context**

As a public health nurse, I have provided care to older adults with diabetes. The trajectory of their condition is often a downward spiral, leading to debilitating complications that negatively impact health, function, and independence. Many older adults develop diabetes complications despite efficient and competent nursing. The onset, progression, and severity of complications arise at least in part to inadequate blood glucose control over time. This problem is not due to lack of desire to control the disease or incomplete knowledge about diabetes management. The problem rests on the difficulty older adults’ face in maintaining sustained lifestyle changes over time. Even after being diagnosed with diabetes, older adults may find it difficult to commit to making lifestyle changes, though they are necessary to improve health outcomes.

Through my association with professional organizations and through personal affiliations, I educate and coach individuals and groups with diabetes and other chronic diseases. I attempt to understand their experiences and provide a venue for them to explore the structures in their life worlds that may hinder or facilitate improved health and healing. These individuals frequently
express concern regarding the progression of diabetes as well as a desire to control the disease to improve their health. Their concerns are often followed by statements or uncertainty regarding their ability to make and sustain lifestyle changes. Remaining motivated is usually the greatest challenge. However, self-management can have various impediments that are unique to each person and relative to all factors within the social context of their daily lives. To better understand how the nurse–person relationship may affect health outcomes for this population, this study allowed participants to describe their experiences with a public health nurse.

From my personal experiences as a Black American woman, I have an inside understanding of the dietary and healing practices of older BA. Many BA cannot resist traditional foods, which contribute to a diet high in fats and carbohydrates. This diet often leads to the onset of diabetes and complicates efforts to maintain adequate blood glucose control. I believe that many older BA distrust the medical community and take personal responsibility for their own health and healing. I think of my own mother who developed high blood pressure in her early 50s. Other than having high blood pressure, she was quite healthy. My mom believed antihypertensive medicine would cause her more harm than good. Even though family and friends encouraged her to take the medication, she continued to use herbs and self-treatments in an attempt to manage her blood pressure. She had a stroke five years ago, which could have been avoided if not for her distrust of physicians and medical practices.

**Theoretical Context**

Nursing care of elderly BW living with diabetes may be viewed as transpersonal relationships with intentionality—in essence embracing the other in a trusting, respectful manner to affect health and healing of each unique person. Therefore, the transpersonal relationship is an intersubjective human process; the nurses’ way of being with the client in this process influences
the nurse-person relationship. The process encompasses mind, body, and spirit in a united and complex fusion, which is not well understood but is vital to the power of nursing care and healing (Bulfin, 2005).

While providing care to individuals is not unique to nursing, research framed in nursing science will generate new understanding and descriptions unique to this context. Nursing as a human science occurs during the nurse–person interaction, in the moment when the actual face-to-face meeting occurs (Travelbee, 1971). This moment represents the enactment of nursing care in mutual and reciprocal human-to-human relationships that are not limited to the dominate features of conventional science (Halldorsdottir, 2008). In the presence of the client in the human-to-human relationship, the meaning of the human subjective response may be explored, allowing the meaning of the human condition to unfold. Within the care moment and the nurse-person relationship, nurses affect health and healing (Halldorsdottir, 2012).

Human science provides a unified framework for nursing practice, education, and research that may be applied across disciplines, while shifting away from the previously predominant medical model approach to the delivery of nursing care (Halldorsdottir, 20008). This shift includes and provides an alternative to the analytic perspective of health–illness–healing experiences in the context of inter-human relationships, accommodating all ways of knowing (Watson, 2012) and the essence of nursing. It is important to understand the ways nursing care is enacted in practice and how the nurse-person relationship affects the lives of people that nurses care for.

**Compassionate Competent Nursing Care**

The nurse–person relationship is central to nursing knowledge and is the means for providing compassionate competent nursing care to people (Halldorsdottir, 2012). This
relationship is an intersubjective interaction in which health and healing occurs (Paterson & Zderad, 2008). Before the nurse-person relationship can be established, nurses’ introspection and self-awareness of how they view others are essential. Nurses must be free of biases and open to recognizing and valuing each person as unique and deserving of respect. The nurse encompasses a holistic and humanistic nursing perspective in cultivating the relationship, conveying that they are present in a person’s journey toward health and healing, respecting and appreciating their differences, giving of self, and serving humanity (Watson, 2012). The nurse promotes trust and establishes a relationship characterized by authenticity and responsiveness in a shared experience (Halldorsdottir, 2008).

The value of nursing as a human science comes from knowledge created within the shared lived experience in unique nursing situations (Boykin & Schoenhofer, 1993/2001). The intersubjective nurse-person relationship itself may be considered a nursing care intervention, implemented to establish trust, faith, and hope (Halldorsdottir, 2008). Intersubjective relationship-centered nursing care influences the health and healing experience in a holistic way that transcends physical illness and preserves human dignity (Halldorsdottir, 2008).

Halldorsdottir (2008) constructed a theory on the person’s perspective of the nurse-person relationship which has expanded to Nursing as Compassionate Competence Theory on Professional Nursing Care. Halldorsdottir focused on fundamental aspects of the nurse-person relationship as perceived by the person. Walker and Avant’s (1995) theory synthesis method (as cited in Halldorsdottir, 2008) was used to analyze the findings. Key concepts and statements pertaining to characteristics of the nurse-person relationship were synthesized from patients’ reports in phenomenological studies including Halldorsdottir, Halldorsdottir & Karlsdottir, and Halldorsdottir & Harmin (as cited in Halldorsdottir, 2008). A literature search was conducted to
identify variables related to characteristics of the nurse–person relationship. Relational themes were compiled into one major statement about the nurse–person relationship, which encompassed eight major tenets.

Halldorsdóttir (2008) uncovered eight major tenets of the nurse–person relationship from the patient’s perspective. The nurse–person relationship is basic to professional nursing care and one of its most important aspects. Prerequisites for the development of a nurse–person relationship include the nurse genuinely care for the patient as a person and patient and having professional wisdom (both knowledge and experience) and competent nursing skills. The patient can trust the nurse who fulfills these prerequisites. Once trust is established, a connection is developed, while at the same time, a comfortable distance of respect and compassion is maintained. Halldorsdóttir (2008) used a bridge as a metaphor to symbolize open communication and the connectedness patients experienced in nurse–person relationships. A wall symbolized nurse–person interactions that were perceived as uncaring. Five phases were identified in the development of a nurse–person connection from the patient perspective: reaching out, initiating, and making a connection; removing the masks of anonymity; acknowledging the connection; reaching a level of truthfulness; and establishing a sense of solidarity and true negotiation of care. In order for the nurse–person relationship to be life-giving the nurse must be a life-giving person (Halldorsdóttir, 2008). The positive consequences of a nurse–person connection can be summarized as empowerment, and the negative consequences of the wall can be summarized as discouragement or even disempowerment.

Halldorsdóttir (2008) proposed that the core characteristic of the nurse–person relationship from the person’s perspective is a dynamic spiritual connection, an energizing bond. This bond, in its highest form may be “life-giving” and very empowering for the person. The
life-giving bond can be equated to a healing relationship. The nurse–person relationship was described as a central to increased health and healing for the person (Halldorsdottir). The nurse–person interaction may also be perceived as uncaring; from this perspective, distressing experiences and outcomes follow.

The focus of this study is the lived experience of elderly BW aging with diabetes, how they perceive their relationships with nurses, and the meaning the experience holds for them. This study explored the women’s individual searches for meaning in the relationship with nurses as co-participants in the human healing process that goes beyond their health condition or life situation. Emphasis is placed on exploring the human experience through listening to the women’s stories to better understand their perception of nursing care and its connection to healing, regardless of the external health condition.

**Summary**

Chapter II described the evolution of this study of aging with a chronic disease within a historical, experiential, and theoretical context. Theories and research in care for older people have illuminated the need to focus on individuals’ perceptions of the nurse-person relationship to better understand how nursing care may be enacted to affect health and healing. The history of aging in America for BA and people of European descent was also presented to better inform the evolution of the study and illuminate the importance of issues related to aging within nursing education, research, and clinical practice. The personal and experiential sequence of events that directed me to this research path was also discussed. Halldorsdottir’s (2012) Nursing as Compassionate Competence Theory on Professional Nursing Care was discussed as the theoretical framework to guide this study. Chapter III will describe the phenomenological research method chosen for this study.
CHAPTER III

Phenomenological Methodology

The purpose of this study is to explore the lived experience of aging BW with diabetes perception of their relationship with nurses, and the meaning the experience holds for them. The method used to conduct this research is Max van Manen’s (1990/1997) hermeneutic phenomenology. This method is a systematic process that uncovers and describes the internal meaning and structure as one’s day-to-day life in the world. Phenomenology is defined as a process of discovering and describing the internal meaning as it is lived in a person’s everyday life (van Manen, 1990/1997). This methodology will be used to uncover the meaning in which the human experience is lived and within which the context of exact experience can be studied (van Manen, 1990/1997).

Phenomenology is both a method and a philosophy used to describe phenomena (van Manen, 1990/1997). As a philosophy, phenomenology attempts to explore phenomena as they are experienced by a person within the social context of daily life (Moran, 2002). Phenomenological research is conducted in the “life world” and essentially reflects the contextual realm of a person’s everyday life (van Manen, 1990/1997). Exploring a phenomenon in the life world allows the researcher to observe and perhaps understand it as it is lived and experienced by the person (Moran, 2000). Through intense exploration and observation, the true essence of the experience may be revealed (Dahlberg, 2006, p. 13). The essences of a phenomenon are those characteristics that make it unique, “without which it would not be that phenomenon” (Dahlberg, 2006). Phenomenological research seeks to study the structure of a phenomenon to reveal how the essence of that phenomenon is manifested (van Manen, 1990/1997).
Rationale for Selection

In this study, the lived experience of aging BW with diabetes perceptions of the nurse-patient relationship was explored and the meaning the experience holds for them was the phenomenon of interest. This phenomenon was explored within the structural context of the life world of the BW. Manifestations of this phenomenon were revealed in the rich descriptions related by the women about their lived experiences. The phenomenological–hermeneutic method was selected to investigate this phenomenon for two reasons. First, phenomenology is appropriate when little is known about a phenomenon (Crabtree & Miller, 1999). As previously stated, the changes that BW may encounter as they age with diabetes and their relationships with nurses are not fully understood. To that end, this study may contribute knowledge to nursing science and the growing bodies of research on aging with diabetes in BW and the nurse-person relationship as a human phenomenon. Second, hermeneutic phenomenology provides the foundation for human science research needed to elicit rich, insightful descriptions of how a person experiences the world (Dahlberg, 2006; van Manen, 1990/1997).

The hermeneutic phenomenological method was chosen for this study because it allows access to the lived experience of BW aging with diabetes, how they perceive their relationships with nurses, and the meaning the experience holds for them. This insight facilitated the creation of linguistic descriptions to reveal the essence of the lived experience for these women aging with diabetes. Here the researcher had an opportunity to listen and learn about the experiences and perceptions of BW and their relationship with nurses.

Through reflective awareness of BW’s experiences aging with diabetes and the nurse–person relationship, BW may become more aware and informed about these experiences (van
Manen, 1990/1997). To gain better understanding of how nurses may better care for individuals with chronic disease such as diabetes, the human science approach has value because it explores human experiences as they are lived by individuals. To effectively support individuals aging with diabetes and to improve health outcomes, the experiences of these individuals must be understood from their point of view. To attribute how events are perceived, the essence of human consciousness is experienced in the first person and is defined by the first person.

**Background of Method**

The term phenomenology first appeared in 18th century philosophy texts. However, Edmund Husserl (1901/2003) used the term in his work “Logical Investigations,” to distinguish phenomenology as a different way of practicing philosophy. Husserl believed that the hypothetical and theoretical methods employed to practice philosophy during his time were antithetical to gaining true knowledge and understanding human problems (Dahlberg, 2006). Husserl’s philosophical perspective was focused directly on analysis of “the things themselves”—the matters at issue *(die Sachen selbst)* (Husserl, 1901/2003). He believed that the concern of psychology was to explore the natural conditions of people’s experiences and the experiences of thinking and knowing.

Edmund Husserl incorporated bracketing in phenomenological practice (Husserl, 1901/2003). Bracketing refers to shedding all biases and knowledge prior to conducting a research study (Lopez & Willis, 2004). Husserl (1964/2010) posited that the researcher’s assumptions and biases could distort the research process, preventing the true essence of the phenomenon from emerging. Some of Husserl’s followers did not ascribe to bracketing and formed their own methods of practicing phenomenology. In 1927 Martin Heidegger published “Being and Time.” This led to the start of phenomenology as it is now known and practiced,
which includes the combined works of Edmund Husserl and Martin Heidegger. Currently, the practice of phenomenology as a research method and as a philosophy is diverse. Several forms of phenomenology exist, and they exhibit both similar and different views.

The two major forms of phenomenology are descriptive (eidetic) and hermeneutic (interpretive). Both descriptive and hermeneutic phenomenological approaches are frequently used to guide nursing research because they are concerned with understanding human phenomena (Wojnar & Swanson, 2007). Lopez and Willis (2004, p. 727) reported differences between descriptive and interpretive phenomenology as “how the findings are generated and how the findings are used to augment professional knowledge.” First, descriptive phenomenology as developed by Husserl uses bracketing to maintain objectivity and remove all biases from the study (Dowling, 2007). Husserl (1964/2010) believed that the focus of phenomenology was knowledge (epistemology). Heidegger (1962/2008), the developer of hermeneutic phenomenology, studied under Husserl and concurred with him regarding “to the things themselves,” accepting phenomenology as a descriptive science. However, Heidegger was opposed to bracketing (eidetic reduction), believing that the focus of phenomenology was the nature of being (ontology) (Heidegger, 1962/2008). Heidegger’s view of phenomenology is hermeneutic, which means interpretation in context, especially social and linguistic context (McManus-Holroyd, 2007). Hermeneutic phenomenology is a human science that studies people within the social context of their life world (van Manen, 1990/1997).

Edmund Husserl

Edmund Husserl (1859–1938) was the founder of the 20th century philosophical tradition of phenomenology. Husserl believed that Western philosophy and science were limited by a one-sided empirical view (Husserl, 1964/2010). He broke away from the empirical view of
philosophy that was popular in his time and developed the phenomenological method based on
the premise that knowledge was derived from the essence of the lived experience (Dahlberg, 2006). Husserl (1901/2003) constructed the phenomenological method as a scientific approach to extract the essential components of the lived experience. His insights launched a new philosophy and a new approach to scientific inquiry (Moran, 2000).

Husserl’s (1901/2003) central insight was consciousness as the condition of all human experience. He sought to explain how to overcome personal biases, which impede achieving a state of pure consciousness. Husserl (1901/2003) considered phenomenology as the science of the essence of consciousness. He focused on developing a deeper understanding of the meaning of lived experience from the first-person point of view. Husserl (1901/2003) proposed that most human experiences involve multiple complex intentions, which led to the development of intentionality, a central concept in his theory of phenomenology, influenced by Franz Brentano. Intentionality is an individual’s conscious awareness of what is happening around them. An examination of intentionality allows the researcher to understand a phenomenon and uncover its essences (Dahlberg, 2006).

Another assumption underlying Husserl’s approach to the study of human consciousness was that certain features of any lived experience are common to all persons who have that experience. These features are referred to as universal essences, or eidetic structures (Husserl, 1901/2003). Husserl proposed that common features, the essences of the experience, must be identified to adequately describe the true character of the phenomenon. Through rich descriptions of the lived experience, the essences of the phenomenon are revealed (Dahlberg, 2006). Husserl further proposed that the essences of the experience should be abstracted without consideration of the context in which the experience occurs. This represents Husserl’s attempt to
make phenomenology a rigorous science. This desire for scientific rigor underlies the use of the bracketing technique (Lopez & Willis, 2004).

Husserl (1901/2003) believed that to understand consciousness, knowledge of essences could only be accomplished by the researcher bracketing all prior personal knowledge, assumptions, or biases regarding the phenomenon to be studied. The procedure of bracketing is called epoche, which is an important strategy to allow the essence of a phenomenon to emerge; in this way, the researcher may gain insight into the common features of any lived experience (Dowling, 2007). The goal of the researcher is to achieve transcendental subjectivity, a Husserlian concept, which means that the impact of the researcher on the study is constantly assessed and the effect of biases and preconceptions reduced, so that they do not influence the study (Husserl, 1901/2003).

**Martin Heidegger**

Martin Heidegger (1889–1976) was a German philosopher who studied under Husserl. Influenced by both Husserl and Soren Kierkegaard, Heidegger combined existential philosophy with the phenomenological method (Tillich, 1944). Through his work “Being and Time,” Heidegger extended phenomenology beyond Husserl’s concept of intentionality by applying the phenomenological method to study the meaning of Being (Moran, 2000). He therefore conceived a more ontological view of phenomenology. Heidegger (1962/2008) believed that the study of Being could only be accomplished through hermeneutic (interpretive) phenomenology, and the interpretation of human existence must include the involvement of the researcher.

Heidegger posited that Being (i.e., presence in the world) was the primary concern of phenomenological inquiry (1962/2008). The Being of something is the nature or meaning of that phenomenon. Heidegger (1962/2008) introduced the concept of dasein (the human way of being
in the world). The term, being-in-the-world, was used by Heidegger to emphasize that humans cannot remove themselves from the circumstances that influence their choices that give meaning to lived experiences. Therefore, a central tenet of hermeneutic inquiry is what the individual’s narratives imply about their everyday experiences (Lopez & Willis, 2004). Heidegger’s (1962/2008) phenomenology attempts to address the situatedness of individual’s dasein in relation to the broader social, political, and cultural contexts. Heidegger further stated that human existence takes place in time, and therefore Being must also be understood in terms of time (Moran, 2000).

Heidegger used the term life world to express the idea that realities are influenced by the world in which the individual lives (1962/2008). The objective world (das Vorhandene) is a late product of immediate personal experience (Tillich, 1944). Therefore, an individual can reflect on past personal experiences in an objective way. According to Tillich (1944) the principle of personal existence or existential subjectivity is not exclusively objective or subjective. Individuals may describe their experiences based on their own perceptions of reality; however, those experiences are influenced by their life world (Tillich, 1944). Werkmeister (1941, p. 41) through personal communication with Heidegger determined that an important aspect of Heidegger’s phenomenological perspective includes the idea that, “we experience specific contents, in and through those contents, we become aware of ‘being as such’, that is we become aware that there is content at all.” In other words, an individual’s perception of their experiences is shaped by the social context of their daily lives.

The assumptions of dasein and situatedness form the basis for preunderstanding, which Heidegger (1962/2008) referred to as the forestructure of understanding. Heidegger assumed that the forestructure is closely linked with how one understands the world and therefore interprets
reality. For this reason, hermeneutic phenomenologists maintain that before conducting an inquiry, a researcher must reflect on past experiences and biases about that phenomenon, so that during the interpretive process they can more clearly access the forestructure of understanding held by the study participants (Wojnar & Swanson, 2007). Additionally, early in the research process, the researcher must reflect on their own past experiences, views, and understanding of the phenomenon to effectively assess the forestructure of understanding held by the participants (Wojnar & Swanson, 2007). Therefore a fusion of the life world of the study participants and the researcher ensues, yielding a new understanding (McManus-Holroyd, 2007).

Max van Manen

Heidegger’s hermeneutic phenomenology informed what is considered the Dutch school of phenomenology. Max van Manen followed the Dutch phenomenological tradition, which incorporates both the descriptive and interpretive methods of phenomenology. Max van Manen’s (1990/1997) approach to hermeneutic phenomenology was used in this study. van Manen suggested that phenomenology is the study of the life world, where life experience is viewed as it is lived. The life world is a person’s daily life experiences, as they actually occur without reflection, categorizing, or conceptualizing (van Manen, 1990/1997). The life world is also known as the lived experience. van Manen proposed that the research design should be flexible and suitable for the phenomenon to be studied because no one method will be appropriate for every inquiry (van Manen, 1990/1997). Phenomenology is a practical and reflective method (van Manen, 2007). The lived experience is the focal point of phenomenological research and “transforming lived experience into a textual expression of its essence—in such a way that the effect of the text is at once a reflective re-living and a reflective appropriation of something
meaningful: a notion by which a reader is powerfully animated in their own lived experience” (van Manen, 1990/1997, p. 36).

Summary

Varied approaches to phenomenology have been posited since Husserl’s Logical Investigations. Each differing philosophical approach grew from a particular view and assumptions about the study of human beings (Caelli, 2001). Hermeneutic phenomenology is concerned with experiences and the meanings of those experiences to the individuals who have them (Willis, 2004). The goal of hermeneutic inquiry is to identify the meanings derived by individuals from their personal descriptions in concert with the researcher’s understanding of the phenomenon (Wojnar & Swanson, 2007). Hermeneutic phenomenology allowed exploration of the day-to-day experiences of elderly BW aging with diabetes and how they perceive their relationships with nurses and the meaning the experience holds for them. Therefore, the essence of the experience was revealed and enables me to grasp the meaning of the experience in new ways (van Manen, 1990/1997). Chapter III has been presented to describe the methodology of the study. Phenomenology was explained and described through the works of Husserl, Heidegger, and van Manen. van Manen’s method of phenomenological research was discussed in terms of six steps.
Chapter IV:
Methodology Applied

Phenomenological Research Approach

A phenomenological method was applied to illuminate the lived experiences of aging BW with diabetes, their perception of relationships with nurses, and the meaning the experience holds for them. This hermeneutic phenomenological approach guided the study to gain a deeper understanding of the essences of the experience as it relates to the nurse–person relationship. Through rich descriptions provided by the participants, interpretation of the meaning of this phenomenon was revealed. Additionally, hermeneutic phenomenology allowed me to go beyond the explicit meaning of the forestructures of the phenomenon to pursue the meaning of the whole and then reconsider it in new ways (Mackey, 2005). Therefore, this human science approach illuminated and offered plausible insights into the life world of aging BW with diabetes, their relationships with nurses, and how those may influence diabetes outcomes.

Max van Manen

According to van Manen (1990/1997), human science aims to explicate the meaning of human phenomena and understanding the lived structures of meaning. van Manen posits that hermeneutic phenomenological research is designed as a writing activity to study human phenomena. Through the writing activities, insightful descriptions of the phenomena are explicated as they present themselves to the conscious mind. Explication of the descriptions is achieved through reflection of the participants’ lived experiences; from that, the structures of meanings (themes) are formed. van Manen suggested that the method of doing hermeneutic phenomenological research is simple: there is no method. He posed six methodological research activities that may be helpful in conducting hermeneutic phenomenological human science
research (van Manen, 1990/1997). This study applied Max van Manen’s Six Research Activities as the methodology for data collection and analysis.

**van Manen’s Six Research Activities**

van Manen’s six research activities will be applied and include the following: turning to a phenomenon that seriously interests and commits us to the world, investigating the experience of the phenomenon as it is lived, reflecting on the essential themes that characterize the phenomenon, describing the phenomenon through the art of writing and rewriting, maintaining a strong and oriented relation to the phenomenon, and balancing the research content by considering the parts and the whole (van Manen, 1990/1997).

1. **“Turning to a phenomenon that seriously interests us and commits us to the world.”** (van Manen, 1990/1997, p. 36)

   Turning to the nature of the lived experience is the object of all phenomenological research, according to van Manen (1990/1997). Through reflection of the lived experience and the desire to make sense of a certain aspect of human existence, a researcher attempt to interpret a phenomenon. This study seeks to understand and interpret the meaning of older BW aging with diabetes and their perceptions of the nurse–person relationship. As a nurse practitioner, I am compelled to study the impact of chronic diseases, such as diabetes, on the day-to-day life of individuals, their families, and the community. The social and personal impact of chronic disease may manifest in several ways, including impaired function, loss of resources, health costs, and adverse effects on family and community health. The nurse–person relationship is a source of support and is critical to health and healing of older BW aging with diabetes. Given that diabetes ages people prematurely, women in their 50s have significant aging issues and warrant nursing care. Nurses are frontline health care providers and are often the people that older women rely on
for support and health decisions. This study of diabetes and aging from the perspective of the nurse–person relationship may bring clarity to this phenomenon by having the women reflect on their perception of the experience. The knowledge gained from this study will shed light on the life world of the participants, including how their perceptions of the nurse–person relationship may influence health and healing.

2. Investigating the experience of the phenomenon as it is lived, rather than how it is conceptualized (van Manen, 1990/1997, p. 53).

This research activity involves older BW’s personal experiences after they are lived, through reflections. Using personal experiences as a starting point, this study aims to understand the nature of the nurse–person relationship from the perspective of older BW aging with diabetes. They were asked to give a direct account of the experience as they lived it, in order to explore and gather experiential narrative material that fostered a richer and deeper understanding of the phenomenon.


Van Manen (1990/1997) suggested four essential themes to guide reflection in the research process. These themes form the fundamental structure of the life world of all individuals and include lived space (spatiality), lived body (corporality), lived time (temporality), and lived human relation (relationality or communality) (van Manen, 1990/1997). To capture and describe the essences of older BW aging with diabetes and their perception of the nurse–person relationship, this study utilized the four existential themes to guide the reflection process.

Lived space or spatiality guides reflection because it is helpful to inquire into the lived space that renders the quality or meaning of a particular experience (van Manen, 1990/1997). To
better understand the relationship between the nurse and person, lived space is a category for inquiring about how they experience the relationship on a day-to-day basis. For example, is the relationship experienced from a distance or within close proximity? Is the distance physical or emotional?

Lived body or corporeality means that we are always bodily in the world (van Manen, 1990/1997). Human beings use their bodily presence to both conceal and reveal themselves. When interacting with others, individuals respond to their sentiments; this may cause them to feel good or bad about themselves. Reflection on lived body existential is salient to understanding the nurse–person relationship because it may reveal what they share and how they influence each other.

Lived time or temporality is the temporal way of being in the world (van Manen, 1990/1997). This is important in the reflective process because it enables understanding of the individuals’ personal life history and what they project in life. This existential perspective assisted this researcher to make meaning of the nurse–person relationship through exploration of past history and how they project future nurse caring behaviors in the management of diabetes.

Lived other or relationality is the relationship that the nurse and person maintain with each other and the interpersonal space that they share (van Manen, 1990/1997). Relationality is also inclusive of other relationships. According to van Manen, these themes are not separate entities but a unified whole that forms the life world. Reflection on the lived experiences that occur in the life world embodies the process of uncovering themes that may facilitate phenomenological description of the nurse–person relationship for older women aging with diabetes.

Writing is the linguistic description of the phenomenological research process. In the final written description, “a structure of a lived experience is revealed to us, and we are able to grasp the nature and significance of this experience” (van Manen, 1990/1997, p. 39). Through the construction of the text, a deeper understanding and the existential structures of the experience are discovered.


A strong and oriented relation to the phenomenon implies that the researcher must maintain a phenomenological attitude of thoughtfulness and tact when conducting research. To this end, I remained oriented to this study to develop the strongest possible interpretation of the phenomenon, therefore enhancing the validity of the study. van Manen (1990/1997) summarized four conditions for enhancing the power and validity of human science research: oriented, strong, rich, and deep. I remained strongly oriented to the study from a nursing perspective to gain clarity about the experience of older black women with diabetes and their relationships with nurses. Rich descriptions of their experiences were documented to gain a deeper understanding beyond the immediate experience.


This research activity is concerned with the overall design of the study and the significance the parts play in the total structure (van Manen, 1990/1997). I attended to the
thoughtfulness of the research question, constantly assessed the overall design of the study and themes that emerged from the research and writing activities.

**Protection of Human Subjects.** Institutional Review Board (IRB) approval was obtained from the City University of New York, Hunter College, prior to the study. After receiving IRB approval, potential participants were invited to participate in the research study and recruited by flyers posted in a church. The flyer contained a description of the study; my name, background, and contact information; and the purpose of the study. Signed consent forms were obtained from each individual who agreed to participate in this study. Prior to data collection all participants received a written document and oral instructions informing them of their rights and a description of the process and purpose of the study. This document informed them that participation in the study is voluntary and that they could refuse to answer any questions or withdraw from the study at any time without negative consequences.

The identity of all participants and organizations will remain confidential. Each participant was assigned a pseudonym, and I am the only person with access to the identity of the participants. This information is maintained in a locked file separate from the rest of the research documents. No one was harmed in the course of this research. Participants were provided with a list of mental health professionals should the need arise.

**Sample Selection.** The participants for this study include BW with diabetes age 65–85 years and had received nursing care to assist them with diabetes management in a community setting. A purposive selection of participants was drawn from members of a church in an urban city. The selected participants met the criterion of having a diagnosis of type 2 diabetes for at least one year. This limitation is based on the assumption that having lived with the disease for at least one year will allow reconstruction of that experience through reflection. Each participant
was assigned a pseudonym to be used when findings are presented to maintain confidentiality. The number of participants was determined to be sufficient when saturation was reached. Saturation was reached when no new information is elicited from the participants after nine participants were interviewed.

**Data Collection.** Random purposive sampling was the method used to recruit participants for this study. This method is appropriate for phenomenological inquiry because it allows the researcher to elicit in-depth understanding of the participants’ experiences from their perspective (Lunenberg & Irby, 2008). Approval was sought and received from the church prior to recruiting participants. Participants were recruited through flyers placed in church bulletins. Potential participants were contacted via telephone and asked if they were interested in participating in the study. Those that agree to participate in the study were screened to ensure they meet inclusion criteria prior to the interview.

Individuals selected to participate in the study were interviewed at location of their choice. In-depth semi-structured interviews were conducted to explore the lived experience of older BW aging with diabetes and their perception of the nurse–person relationship, and data was collected to foster a deeper understanding of this phenomenon. Consent was obtained for digital audio taping of the interviews. Before starting the interview, I obtained signed informed consent and explained the meaning of informed consent and the research process to each participant. Two interviews were conducted with each participant, including the initial interview and a follow-up interview. During the follow-up interview, transcripts were reviewed for accuracy with the participant. A reflective journal was maintained throughout the research process to allow the researcher to document and maintain a record of field notes, reflections, and
circumstances surrounding each interview. During the interview each participant was asked “Tell me about your experience with the nurse.”

**Analysis of the Data.** The participants and I engaged in a dialogue. I identified themes, and both the participants and I assessed the appropriateness of each theme by asking “Is this what the experience is really like?” Interviews were scheduled at the convenience of the participants. The interviews were audio taped and transcribed verbatim. I also took written notes during the interview and maintain a journal of field notes detailing my reflections after each interview.

Once the interview data had been transcribed, the data was analyzed to isolate thematic statements. I applied a holistic approach to analyze the text as a whole. For each interview, I asked, “What critical phrase may capture the fundamental meaning or main significance of the text as a whole?” I then tried to express that meaning by formulating themes. This required a reading and rereading of each interview. Next, the detailed or line-by-line approach was employed to capture themes from the data. Upon completion of the line-by-line reading, a holistic rereading was done to identify essential structures in the data. At that time I employed collaborative analysis to strengthen the study by seeking a conversational relation with colleagues to establish a common orientation to the structure of the themes (van Manen, 1990/1997).

**Rigor.** Rigor characterized by validity and reliability ensures that findings accurately reflect the phenomenon of study (Davies & Dodd, 2002; Sin, 2010). According to Lincoln and Guba (1985), rigor in qualitative designs is evident in a study’s dependability, confirmability, credibility, and transferability. Together, all these verification strategies incrementally and interactively contribute to and build reliability and validity, thus ensuring rigor (Morse, Barrett,
Mayan, Olson, & Spiers, 2002). Techniques to enhance reliability and validity used in this study include member checking, multiple interviews, maintaining an audit trail of analytical decisions, and thick description of the participants’ experiences.

Dependability is the ability of another researcher to arrive at conclusions similar to those of the researcher that conducted the study (Lincoln & Guba, 1985). Dependability in this study was achieved by maintaining all audiotapes, notes, and journals. I kept a personal log and audit trail (Van Manen, 1990/1997) to account for influences on interpretation of the data if an audit is conducted. In addition, themes were critiqued by colleagues to establish appropriateness of the themes and to provide a varied lens to view the data.

Confirmability refers to the researcher’s ability to remain neutral and not contaminate the study with personal biases (Lincoln & Guba, 1985). It also denotes the degree to which the results may be substantiated. Records will be maintained for a period of five years. I engaged in reflexivity to identify and acknowledge assumptions and presuppositions derived from previous personal and professional experiences in order to reduce the potential for bias in the study. A reflective journal was maintained throughout the research process. This facilitated separation of preconceptions and the research findings.

Credibility is the ability to accurately depict the participants’ lived experiences as they perceive them (Lincoln & Guba, 1985). I developed a rapport with the participants through self-disclosure and collaboration to minimize inequality that the participants may have experienced (Creswell & Miller, 2000). During follow-up interviews member checking was conducted to verify with the participants that their lived experiences were accurately represented. Reading and rereading of the data was performed to ensure that relevant data were identified. I conducted interviews until saturation was reached in order to allow creditable themes to be established.
Transferability refers to the ability to transfer conclusions to other settings, which is promoted by selection of purposive sample, research setting, and recruitment methods that are clearly delineated (Lincoln & Guba, 1985). I have clearly described the sample, recruitment methods, and research setting.

**Summary**

This chapter provided a description of van Manen’s six methodological research activities that may be used to conduct hermeneutic phenomenological human science research. Sample, setting, access, interviewing techniques, data collection and storage procedures, data analysis, rigor, protection of human subjects, and feasibility of the study were discussed. Measures to ensure rigor so that the study has value to human science research were also discussed.
Chapter V

Findings of the Study

This phenomenological study presents the lived experiences of aging black women with diabetes nurse-person relationships. This chapter describes processes involved in thematic data analysis to uncover the meaning of the women’s experiences embodied and dramatized in the text (van Manen, 2014, p.208). First, this chapter presents the key findings obtained from nine in-depth interviews, a description of the participants and essences of their experiences are presented. A variety of experiences are provided to allow the research participants descriptions to be fully captured. Quotations allow the participants to speak for themselves, providing multiple perspectives. Next, the essential themes which evolved from all synthesized essences are identified and concluding interpretive statement is presented, based on reflections from the data.

I interviewed nine elderly Black women with diabetes for this study. Each interview lasted between 50 to 60 minutes. The interviews were recorded, transcribe, and the experience of each participant interpreted using van Manen's method for hermeneutic phenomenology. From thematic processes, the structure of the meaning of the nurse-person relationship evolved answering the research question, “What is the lived experience of BW aging with diabetes and their perceptions of the relationship they had with nurses that cared for them at home?” The participants told their personal stories of aging with diabetes and experiences in the nurse-person relationship during the interviews. Listening to their personal stories was a source of rich text that generated deeper understanding of the phenomenon.

I reflected on each transcribed interview several times to grasp the essential meaning of the experience for each participant. To better capture the interview experience, I documented my observations about the participants during each interview. Also, I maintained a journal of my thoughts, feelings, and reflections after each interview, including nonverbal behaviors such as
posture, tone of voice and eye contact, to explore the women’s experiences “… in all modalities and aspects” (van Manen, 1997/1990, p 32). After the tapes were transcribed, a follow up interview was conducted with each participant to ensure the meaning of their experience was accurately captured. The follow-up interviews lasted from 20 to 30 minutes. To gain insight into the essence of a phenomenon requires reflection and clarification of the structure of the lived experience (van Manen, 1997). Rich descriptions of their experiences were documented to gain a deeper understanding beyond their immediate experience (van Manen). The text generated from their personal stories was organized into themes for further reflection and development of the central themes for this study. These themes were further developed into interpretive thematic statements each of which described an aspect of the lived experience of BW aging with diabetes visited at home by nurses.

Reading and reflection of the text was done using three approaches to isolate thematic aspects of aging diabetic BW experiences with nurses. The first approach to reading and reflection was a complete reading of the transcripts as a whole. I uncovered several critical phrases that expressed the fundamental meaning of the women’s lived experiences. Those critical phrases were reflected on for saturation. The second approach I used to reading and reflection, focused on isolating thematic phrases. Texts were read several times, statements that seemed particularly essential or revealing were highlight. Statements that expressed a similar idea or thought were placed in a category. Next, a line-by-line reading of the text was done to identify and code thematic expression that revealed some essence of the women’s experiences. Similar codes were synthesized in groups and themes created to capture the combined meaning of the original codes.
Research Setting

The interviews were conducted in the participant’s homes in the downstate New York metropolitan area. The participants chose a convenient interview time. Most of the women lived alone, for the two that did live with family members, the interviews were held in private locations of their homes. Interviews were taped and transcribed to protect the identity of the participants.

Study Sample

The study participants included nine BA women with diabetes that had or were currently receiving visiting nurse service in their home. The women ranged in age from 65-82 years. All were recruited from a church in the New York City area or by referral by one of the church members. The women lived with diabetes from 4-38 years and had varied health problems related to the effects of the disease.

Study Findings

Participant Experiences

Marie.

“*I have my daughter but she doesn’t really understand. My nurse, she understood what I was going through; she was there with me when I was really struggling with the diabetes.*”

Marie, a retired widow, shares an apartment with her daughter and grandson. She has experienced living with diabetes for 19 years. Marie received home care services following a hospitalization caused by mismanaging her medications.

I met Maria at her home, she was alone, and we set at her dining room table. She sat across from me sipping a cup of tea. Marie said she was comfortable talking about her experience living with diabetes; her voice was soft and steady as she responded to each question.
Marie reflected on what the experience of living with diabetes is like for her, she said, “I used to be able to get on the subway or hop on the bus and go across town, now is getting really hard for me because I don't have the strength. The diabetes has caused my eyesight to get bad and the high blood pressure. I'm concerned about what's going to happen in the future. My daughter already treats me like I’m the child. I don’t want to depend on anyone too much.” She frowned and seemed saddened by her future possibilities. Marie went on to say, “I leave it in God’s hands. I just have to take good care of myself.”

Marie said her experience in the nurse-person relationship made her feel like she could manage her health. She describes her experience with the nurse as very supportive and “comfortable” when she was learning to give herself insulin.

“She was patient. Every day, she was right there with me, we would take another step. We focused on learning one task at a time until I got it. Her encouragement and attitude made me believe I could do it.”

Marie recalls her first encounter with the nurse, she was anxious, faced with the daunting task of learning to self-administer insulin. The nurse sensed her anxiety “She put her hand on my shoulder, and told me to relax and said she would visit every morning to make sure I got my insulin. Her words were reassuring and gave me the confidence to try.”

Marie reflected on aspects of her experience in the nurse-person relationship that were most meaningful and important to her. Marie says living with diabetes is hard and she remembered feeling “encouraged” to continue on the right path to preserve her health. Marie says the nurse made her feel like “I wasn’t in it by myself.” Marie felt she could tell from the nurses actions “she honestly cared about me.” Reflecting on how her experience in the nurse-person relationship impacted her life, Marie said, “Her encouraging words and the things she told
me, I hold on to. When I get a little discouraged or think about not making good choices, her words remind me it’s worth it.” Marie feels a personal connection to the nurse, she said, “She listened to me talk about my family and what was happening in my life. I listened to her talk about her children and what they were doing. We got to know each other, we connected.”

Grace.

“I called it a professional friendship because I feel connected to her. It’s a fact that she healed my wound, the other thing is she made me feel better when I was having a rough time and feeling bad about myself.”

Grace is a retired widow; she resides alone. Grace met me at the front door of her apartment, balancing herself with a cane. We sat across from each other at her kitchen table; she was very attentive and gave good eye contact. She received home care services for treatment of a diabetic wound on her foot. Grace has been living with diabetes for more than 20 years.

As Grace describes her experience, living with the effects of diabetes, she gets very serious. Grace said she noticed it is getting more difficult to perform every day activities. “I'm not as mobile as I used to be. If I walk two blocks, I have a lot of pain in my legs.” Grace felt a growing dependency on others “My niece takes me out or my grandkids walk with me. I'm actually more dependent on my grandkids.” She goes on to express uncertainty about her future health. “I love to sew; I used to enjoy knitting, and doing fine things with my hands. I don't know what it's going to be like if I lose my sight because of the diabetes, I don't know”

Grace was happy to talk about her relationship with the nurse, and said was excellent. “I want her to get all the credit because she healed my wound, yes she did!” Before Grace describes her experience with the nurse, she paused in reflection and gave an emotional account of the first day the nurse visited.
“At first I was frightened because I never had a wound that big. I was also embarrassed because it didn't smell the way I like for things on my body to smell. As soon as the nurse got to my house, she told me to take my pain medicine so it would start working before it was time to change the bandage. We started talking and she asked a lot of questions. While I was talking, my mind was on what her reaction would be when the bandage came off my foot. When she was ready to look at the wound, I started to remove the bandage. She took over. I was getting anxious because it was very painful when the doctor took the bandage off. She wet the bandage completely and removed it so gently; I did not have any pain at all. When that big smelly wound was open and exposed, I looked at her face for a reaction. My embarrassment left immediately. She was very caring and such a gentle caretaker. She sensed I was uncomfortable and catered to making me feel relaxed. I knew I was in good hands from the beginning.”

Grace was energized and emotional as she described aspects of the nurse-person relationship that were most meaningful and important to her. She said the nurse was nice to be around. “She was always smiling, and pleasant, with a great sense of humor. She made me feel better.”

Grace felt the nurse showed so much compassion and concern it healed her body and spirit. Grace recalls an experience with the nurse when the wound was healing slowly and she was feeling depressed. “When I was at my lowest point, she listened to me and treated me like her sister instead of a patient. She wiped my tears and put her arms around me. She made me feel like a whole person again. I knew she sincerely cared about me.”
Margaret.

“You connect with them or you don’t. It’s not like I can send one away if she is not good, it doesn’t work that way.”

Margaret is a retired divorcée; she is blind and lives alone. She has an aide to assist her 12 hours a day. The interview took place in Margaret’s home. I sat at the dining table while she sat in a recliner across from me. She appeared slightly anxious. I asked about her family and she relaxed as she spoke fondly of her daughter and grandchildren that lived out of state. We proceeded with the interview. She expressed frustration at some of her experiences in the nurse-person relationship. Margaret was open and forthcoming with profuse dialogue. She was connected to her feelings and provided descriptive annotations of her experiences.

Margaret has lived with diabetes for almost 40 years. For the past six years, the nurse visits every two weeks to prefll insulin syringes and pre-pour oral medications. She describes her experience living with diabetes, “Having diabetes is terrible, it caused me to lose my eyesight and since then everything went down. I had to retire early, at 62, because I couldn't work anymore.” Margaret expressed feelings of “frustration” with her situation. “I can’t get out of the house unless one of the aides is with me. I don’t ever feel normal anymore.”

Margaret’s experience with nurse-person relationships has been varied; she describes both positive and negative experiences. She feels very connected to the nurse that has been caring for her the past four years and describes this nurse-person relationship as a positive experience. Margaret described the relationship she has with the nurse. She says the nurse shows she cares by going out of her way. ” She'll pick me up something if I need it, especially if it’s somewhere that is hard for me to get to. She is someone I can call on.” Margaret feels the nurse
is smart and “knows her stuff”. “If the doctor tells me something and I don't really believe it or understand, she'll explain it to me.”

Margaret describes the most meaningful and important aspects of her relationship with the nurse. She said the nurse has a great personality, “She has a sense of humor, easy to laugh and joke with.” She was very expressive and lowered her voice to a soft tone. “We have a special relationship, more of a friendship. She is very understanding, and respectful. She treats me like an equal.”

In contrast, Margaret reflected on experiences with the nurse-person relationship that caused negative feelings to emerge. “When my regular nurse is off, and a different nurse comes, they act like I'm not even here. They hardly speak and I hardly speak to them. I am a human being.” Margaret feels some nurses are indifferent and “not respectful.” For Margaret, the nurse was there to “take care of me, not treat me like a child.” She says when some nurses visit, “They want to be in control and act bossy.” She feels, “they don’t care about me.”

**Flossie.**

“Because the nurse took time to share knowledge in a way that is supportive, there was definitely a difference in my blood sugars, it made me believe that I could turn my situation around and I was able to do that.”

Flossie lives alone, a single retiree. For the most part she is independent; however she has a niece that lives close by who takes her shopping. A diabetic for 18 years, Flossie received home care services because her blood sugars were out of control and she needed help managing her medications. I interviewed Flossie in her apartment. I sat at her desk, while she relaxed on the sofa. She said she was quite willing to talk about her experience living with
diabetes. Initially, she was subdued but she became enthralled with telling her story once we started the interview.

Reflecting on her experience living with diabetes, Flossie smiled and said, “For right now, the diabetes really hasn't affected me too bad. The major issues I have are making sure I keep my appointments, control my blood sugar, and not give into the temptation to eat the foods that I love. Flossie admitted that in the past she would not take her medication and disregarded any dietary restrictions.

Upon further reflection, she began to speak in a slow and deliberate tone. She recalled her response when the doctor told her the nurse would visit her at home. “I told him no. I did not want anybody in my space, telling me what to do with my life.” Flossie revealed the anxiety she felt at that time. “I was upset; I felt helpless, hopeless, sad, and anger all at the same time. I remembered feeling the same way when I was first diagnosed with diabetes. “Flossie said, “The diagnosis was shoved down my throat.” She felt, “No one cared about me as a person, I was just a diabetic patient to them”

Flossie began to select her words very carefully as she reflected on her experience in the nurse-person relationship during the nurses first visited. Flossie said she felt an “immediate connection” with the nurse. “She was able to communicate in a way that touched me.” Flossie said the nurse listened and allowed her a chance say how she felt. “The nurse did not judge me or dismiss my feelings, she just listened.” Flossie recalled a sense of relief. “Once I had the opportunity to voice my anger, I was in a better place.”

Reflecting on aspects on the nurse-person relationship that were meaningful and important to her, Flossie felt the nurse understood her, “It was uplifting, I was able face with my feelings. Dealing with my health issues became less stressful … having diabetes.” Flossie said it
meant a lot to have the nurse comfort her. Flossie felt, “It wasn’t just a job to her, it’s who she is, a very caring person.”

Alethea.

“The nurse that came to visit with me, she was very smart. She helped me to learn to take care of myself and understand that to a certain degree, my health is in my own hands. It wasn’t only that she had knowledge; it was also that she had a way about her that she made me feel comfortable talking about my health problems, I could sense she wanted me to get better.”

Alethea lives alone, she is a retired divorcee. Her daughter and grandson live in close proximity. She opened the door to her apartment and greeted me with a big warm smile. She was enthusiastic, and said she was looking forward to the interview. We conducted the interview at her dining room table. She was very engaged throughout the interview, maintaining good eye contact. Alethea has lived with diabetes for 16 years. Reflection on her experience living with diabetes and its effects on her health, she says, “Living with diabetes, as you get older, the diabetes gets worse. For me, it brought heart disease and problems with my legs. I can’t get around anymore.” Alethea summarizes her feelings about the experience of aging with diabetes, “I’m an older woman, but I’m not old, old. I still want a full life. I feel like I lost something, a part of me that I can’t get back.”

Alethea reflects on her experience in the nurse-person relationship at a time when she was uncertain and unable to care for herself. The nurse visited on her first day out of the hospital; she was alone and very weak. Alethea felt the nurse understood her situation and did everything in her power to care for her. Alethea said:

“She arranged for the medications to be delivered and aide services started that same day. She was so kind, very professional and humble, very caring. I don’t know how I would
have managed without her. I could feel her sincerity and genuine interest which meant a lot.”

As Alethea continued to reflect on her experiences in the nurse-person relationship, she described her feelings and aspects of the relationship that were meaningful to her. Alethea felt the nurse provided guidance and support and always “took that extra step” to assist her during the recovery process. Alethea recalls when the nurse recommended physical therapy which she refused. She conceded when the nurse emphasized the benefits. Alethea said,” It really helped me get stronger. She offered physical therapy service and I refused. She had done her job but she encouraged me because she knew it would help. That lets me know it’s not just a job to her, she really cares about what she is doing.”

Alethea became very emotional as she recalled this experience when she was having a really bad day. She felt the nurse was very attentive and sensitive to her situation. She said:

“I was thinking I'm not old, old and I still want to enjoy life, an overwhelming sadness came over me. It was like the nurse sensed something, minutes later, she called. I told her how I was feeling and she came right over. I was touched! All the bottled up feelings inside came out, I cried and exhaled. I felt like I was at home with a friend who understood. I still feel a connection, she was very supportive when I was in a difficult place and didn’t have control of my situation.”

Laela.

“She made me feel like she cared about what happened to me. She was knowledgeable and showed an interest in doing her best for me, to make sure that I was ok”.

Laela lives alone, a retiree widow. She has a housekeeper for four hours a week, otherwise she is independent. Laela has lived with diabetes for over 25 years. She received
home care services following a hospitalization. The nurse visited to provide follow up care in her home.

I interviewed Laela in her living room. I sat on the sofa; she reclined in a large chair. She said she has lived with diabetes for a long time and no one ever asked her to talk about it. She was happy to share her story and hoped it would help others. Lela was very pleasant, smiling throughout most of the interview. She maintained good eye contact, looking away occasionally when thinking of something she wanted to say.

Laela has lived with diabetes since she was in her early 50s. Reflecting on her experience living with the disease at this time in her life she describes increased health problems as the complications of the disease progress. Laela says “It’s really getting me down”. I try to focus on other things and stay in prayer. Laela started on oral medications, now she takes insulin twice every day. She describes debilitating pain in her legs. “I can’t even clean my own house anymore because of the pain in my legs.” Laela summarizes the meaning this experience has for her. “That's what I have to live with now, I don’t mind getting old but feeling old, I can live without.”

Laela reflected on what her experience in the nurse-person relationship was like. She felt the nurse showed compassion which “allowed me a chance to adjust to living with my illness”. She recalls when the nurse visited after she was discharged from the hospital. Laela said the nurse was “very supportive and knowledgeable.” Therefore able to “connected me to the services I needed to be safe living at home”. Laela said the nurse spent time talking with her about various things, “especially what it was like for me living alone with my health problems.” Laela expressed feeling cared for by the nurse which allowed her to “open up”. Laela said the nurse was concerned with, “everything that affected my health.” She responded by talking about her struggles. “I let her know I was not managing well by myself, my legs are bad and my sight is
going.” Laela said the nurse helped her get situated at home. “She arranged for the pharmacy to deliver my medicine and the doctor comes here for my appointments. She also got an aide which I thought I would never accept but the aide is really helpful and a blessing. This made living alone a safe situation for me.” Laela summarized the experience by saying, “She made a difference, I don’t feel isolated anymore.”

Helen.

“The nurse was really a kind and caring person. I think she is an excellent nurse. She went that extra mile to help me solve an overwhelming problem. I know she probably treats all her patients well, I’m just glad she was here for me.”

Helen is a retiree; life is centered on caring for her husband with dementia. She has lived with diabetes for 10 years. Helen received home care services because her blood sugars were out of control and her kidneys were affected. She also needed help caring for her husband.

I interviewed Helen in her home. After I waited for her to get her husband situated, she then turned her attention to the interview. We sat at her dining room table. She took time to reflect on her experiences, giving considerable thought to each question. She maintained eye contact. Helen’s speech was fluid; she described her experiences in detail with few prompts.

Reflection on her experience living with diabetes, Helen says her health is in jeopardy because of diabetes complications. Helen has high blood pressure and her kidneys are starting to be affected. Helen has a family history of diabetes. She said, “Even though I knew what it was and what it could do…. I had only seen, not experienced it.” Helen expressed difficulty with self-diabetes care. She says, “It sounds easy when someone tells you to change your diet and take these medications every day. Integrating those changes into everyday life, that’s not easy.” Helen
paused and became very serious as she said, “I have to preserve my health. I worry about what’s going to happen to us if I get sick.”

Helen reflected on her experience in the nurse-person relationship, she recalls talking to mostly about her husband during the first visit. Helen says, “I know she was not here for my husband, since that was my main concern she let me go on.” She recalled how relieved she felt to “connect” with someone that “understood” her situation. The most important thing to Helen was “she cared enough to listen.” Helen said the nurse suggested available to help care for her husband. Helen recalls talking with the nurse. “She was not forcing, she just gave me some things to think about.” Helen describes the nurse as “helpful.” She recalls feeling “overwhelmed” taking care of her husband and “neglecting” her own health. Helen said, “She looked beyond my disease and her job, she looked at my whole life and made a difference.” As Helen reflected on how the nurse-person relationship impacted her life, she stated, “I felt supported and cared about.”

**Emma.**

“It was the little things the nurses did that made the experience outstanding, like being patient and not rushing.”

Emma is divorced, lives alone has been retired for the past three years. She remains independent; however functional limitations are a concern. Emma was diagnosed with diabetes four years ago. She received home care services to help manage her diabetes. I interviewed Emma in the kitchen of her apartment. She constantly rubbed her legs which she said hurt all the time. Otherwise she focused on the interview questions and gave sufficient thought to reflecting on her experiences in the nurse-person relationship. Emma maintained good eye contact and expressed interest in telling her story.
Reflecting on living with diabetes at this time in her life, Emma expressed disappointment with the limitations and restrictions the disease causes. “I don't eat a lot of the things I like. I have to think about how my body is going to respond. Like eating a piece of wedding cake when my niece got married, I just wanted a small piece but I don’t want to take the risk.” Emma continues to describe what living with diabetes is like for her. She says, “I have a sister we used to travel. We planned to travel extensively after we retired. That’s not going to happen, I can't sit on a plane, and I could not take the pain in my legs. That is what the diabetes has done to me. Even going outside to the store or getting on the bus is a problem.”

Emma reflected on her experience in the nurse-patient relationship, Emma felt nurses were “very warm and caring”. Emma gave an account of a caring experience. She said, “I needed my medication and I could not get to the pharmacy. The nurse left my house after her visit, picked up the medicine and brought it back to me, so I would not miss a dose.”

Reflecting on what the experience with the nurse was like for her, Emma said she needed help managing the diabetes and recalls the reason the nurses were visiting her. “I was not doing my part. The medication is not going to work if I don’t take it.” Emma recalls her experience with a nurse whom she describes as "helpful". Emma felt, the nurse "guided instead of directing” her. She says, “She listened to what I was saying and understood what I was feeling.” Emma said the nurses spent time with her and gave “that extra attention “which was a motivating force. “She was involved and showed concern this encouraged me.”

Reflecting on what was most meaningful and important to her in the nurse-person relationship, Emma said, “She did not judge me or scold me because I wasn’t taking my medications. She did not give me advice.” Emma felt the nurse “gave me options to think about and the possibilities associated with different options.” Emma said the way the nurse
communicated with her conveyed respect. “She treated me like an individual, it felt good to feel I had choices instead of always feeling helpless and out of control.” Emma described one way she experienced the nurses caring and concern. “Sometimes the nurses would call me on the phone between visits, just to show concern, or remind she was available to me.”

Ruth.

“She includes me in everything that's going on, talks with, me ask me how I want to manage things and gives me choices about what I can do. It’s important to me that she don’t make me feel like I’m just some old lady, but I matter to her.”

Ruth lives alone, a widowed retiree. She is confined to a wheel chair. Ruth receives ongoing home care services. The nurse visits every two weeks to pre-pour medications and supervises the aides. She nurse also provides care coordination of services and benefits. Ruth also has 24 hour aide assistance. She has one son that lives out of state, he calls daily and visits often.

I interviewed Ruth in her apartment. She sat in her wheel chair; I was at the kitchen table. She thanked me for giving her a chance to tell her story. Ruth said she thought about writing a book about her experiences living in this situation. She was animated and quick to point out the humor in her life. She maintained good eye contact throughout the interview.

Reflecting on her experience living with diabetes, Ruth describes what her life is like at this time. One of her legs was amputated. Ruth chose not to spend her life in a nursing home. She arranged to live home with 24 hour aide service. Ruth spoke of her struggles with independence but remains optimistic. She said:

“It’s not so bad when I can get out, trapped in this old body, I not going far. During the summer I make it my business to go out.” Through all that has happened, the Lord is
keeping me here for a reason, and I don’t question Him. Every day is a struggle. I try to keep myself busy. I used to take care of everybody but now I need someone to take care of me. Ruth says, “It is hard to get used to but I guess that’s just how life goes. You know, once a man, twice a child. I believe everything has a time and a season.

Through the side bar comments and laughter, there was sadness in Ruth’s voice as she continued to describe her experience aging with diabetes and the challenges she faces. She says: I’m in the winter of my life. When I wake up in the morning … enjoy the birds singing because tomorrow is not promised to me. Even though you don’t hear any birds singing in the Bronx (laughs). She speaks of multiple losses, her husband, friends and relatives and includes loss of herself. “My major challenge is my body doesn’t work anymore but my mind still wants to carry on like I was thirty five (she laughs).”

Reflecting on her experience in the nurse-person relationship, Ruth feels it would be impossible for her to live home without good care and support. Ruth describes this as “being responsive, following up on things.” Ruth says she can depend on her regular nurse, who shows concern and goes out of her way to make sure everything is correct. “A couple of months ago, for some reason my Medicaid expired, I did not get any notice in the mail. When the nurse called for the prescription refill, the pharmacy would not deliver the medicine. The nurse was on the phone for over an hour until she fixed the problem.”

Reflecting on the most meaningful and important aspects of the nurse-person relationship to her, Ruth said she feels the nurse has her “best interest at heart.” Ruth feels a connection to the nurse that is “personal and still professional, is not just business.” Ruth says, “I can call her even when she is off and she will take time and listen and show compassion and understanding.” Ruth describes the nurse as someone who supports her autonomy. Ruth says, “She includes me in
everything that's going on, talks with, me ask me how I want to manage things and gives me choices about what I can do. It’s important to me that she don’t make me feel like I’m just some old lady, but I matter to her.”

Ruth recalls an experience in the nurse-person relationship when she felt the nurse was not caring. Her blood glucose was high and she feared it might indicate a bladder infection. Ruth had previously encountered this situation. She requested a nursing visit for further evaluation. Ruth described her experience with the nurse. She said, “She did not speak, she did not smile. All she said was are you the patient and what is the problem.” Ruth recalled how she felt. “It made me feel really bad. I had a bad feeling in my spirit.”

**Thematic Analysis**

Thematic analysis guided the discovery and structure of the meaning of the phenomenon in this study. After each interview was conducted and the audio recording transcribed, I listened to the recordings and read the transcripts simultaneously to assess for exactness. I then met with the participants for a second interview. These interviews lasted 20 to 30 minutes. In this subsequent interview member checking was conducted to verify accuracy of the transcripts. The transcripts were read by the participants so they could reflect and explore deeper meanings of their own experiences. Together with the participants to ensure their views have been properly captured, I weighed the appropriateness of the text by asking, “Was that what the experience was really like?” The participants were reflective and actively engaged in discussing the text and their related personal experiences. The second interviews brought clarification to some of the experiences; however no further insight was discovered during these reflections.

After this process of member checking, frequent cycles of reflecting on emerging thematic patterns in the data and re-coding integrated data sets ensued. Applying the holistic approach I read the transcripts a second time to identify thematic patterns in the data. I identified
statements and phrases from transcribed interviews that revealed fundamental meanings of the phenomenon of the lived experience of BW aging with diabetes and their perceptions of the caring–healing relationship with nurses as a whole (van Manen, 1997/1990). The fundamental meaning of the women’s experiences were formulated into six significant statements: 1) offering self with open heart, 2) going beyond, 3) making connections, 4) transforming, 5) being viewed as a whole, and 6) finding meaning. Reflections from the women’s critical statements coded under each of the fundamental meanings were re-read and analyzed.

At this point, I applied the selective approach to analyze the transcripts by re-reading, highlighting, and reflecting on critical statements of the women’s experiences that revealed the fundamental meanings (van Manen, 1997/1990). Each of the critical statements was clustered with their identified fundamental meanings. Appendix B presents raw data of each woman’s critical statements.

After that, reflecting on critical statements, I applied the line-by-line approach to reading the transcripts. I read each sentence carefully and asked “What does this statement reveal about the nature of the women’s experiences?” (van Manen, 1997/1990). Throughout this analytic process, thematic statements were clarified and collapsed and finally reduced to initial themes. These initial themes were reflected on and incidental themes were identified and eliminated. As the result of this constant comparative process, eleven preliminary themes emerged which corresponded to the fundamental meanings (Table 1).
Table 1: Grouped Fundamental Meaning and Preliminary Themes

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<tr>
<th>Fundamental meaning</th>
<th>Preliminary Theme</th>
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</thead>
<tbody>
<tr>
<td>Being viewed as a whole</td>
<td>1. Recognition of the mind-body-spirit connection</td>
</tr>
<tr>
<td></td>
<td>2. Intentionality in caring-healing and wholeness</td>
</tr>
<tr>
<td>Making connections</td>
<td>3. Deepening relationships</td>
</tr>
<tr>
<td></td>
<td>4. Identifying self in relation to another</td>
</tr>
<tr>
<td>Transforming</td>
<td>5. Finding a deeper meaning beyond suffering</td>
</tr>
<tr>
<td></td>
<td>6. Helping another to grow in the human experience</td>
</tr>
<tr>
<td>Finding meaning</td>
<td>7. Acceptance of reality and finding hope in the situation</td>
</tr>
<tr>
<td></td>
<td>8. Making meaning in the human experience</td>
</tr>
<tr>
<td>Offering self with open heart</td>
<td>9. Reaching out to another transcending self</td>
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<tr>
<td></td>
<td>10. Offering love and compassion</td>
</tr>
<tr>
<td>Going beyond</td>
<td>11. Forming a trusting relationship beyond the boundaries</td>
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**Essential Themes**

**Determining Essential Themes**

An essential theme is a universal quality that makes a phenomenon what it is and without that universal quality, the phenomenon would not exist (van Manen, 1997/1990). To determine essential themes, van Manen proposed the use of free imaginative variation, deleting a theme from a phenomenon then verifying if that phenomenon loses its fundamental meaning. The eleven preliminary themes were further examined along with the women’s critical statements using free imaginative variation to verify their essential relationship to the experience of BW aging with diabetes and their perceptions of relationships with nurses that cared for them at home. I consulted an expert in nurse researcher to establish appropriateness of the themes which
provide a varied lens to view the data. This expert participated in the final analysis, reviewing the decisional audit trail and posing questions to confirm or refine emerging themes, establishing complementary supportive evidence for a richer and deeper thematic analysis (van Manen, 1997/1009). After reflecting upon the eleven themes, it was determined that themes 1 and 2 could be collapsed into one theme, themes 3 and 4 could be combined; themes 5, 6, and 7 were collapsed into one theme; theme 8 was eliminated; and themes 9, 10, and 11 were also collapsed into one theme. From this process, four fully interpreted themes emerged:

1. Reaching out with concern to the inner life world and subjective meaning of another.
2. Authentically identifying self with another in a humanistic connection.
3. Fostering growth and self-actualization in the illness experience.
4. Being with another in love and compassion, beyond the boundaries.

These four interpreted themes were reviewed to capture the true essence of the women’s experiences. In the final analytic schema, from the interpreted themes, I created four essential themes that captured the essences of the women’s lived experiences (Table 2).
Table 2: Essential Themes

<table>
<thead>
<tr>
<th>Interpreted Themes</th>
<th>Essential Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reaching out with concern to the inner life world and subjective meaning of another</td>
<td>Dwelling with another in mutuality</td>
</tr>
<tr>
<td>2. Authentically identifying self with another in a humanistic connection</td>
<td>Being an authentic presence in the moment</td>
</tr>
<tr>
<td>3. Fostering growth and self-actualization in the illness experience</td>
<td>Creating opportunities to achieve a higher level of wellness in suffering and illness</td>
</tr>
<tr>
<td>4. Being with another in love and compassion, beyond the boundaries</td>
<td>Developing trust in a loving and compassionate human-to-human connection with another</td>
</tr>
</tbody>
</table>

Phenomenological writing produces textual research data that allows the fundamental nature of the lived experience to be interpreted and understood (van Manen, 2007). This textual data should be sensitive to the experience as it is lived and provide sufficient descriptions to explore the meaning of a phenomenon by offering possible interpretations (van Manen). For each of the essential themes, narratives of the women’s descriptions and interpreted meanings of their experiences are provided.

**Essential Theme 1: Dwelling with another in mutuality**

I condensed theme 1, “Recognition of the mind-body-spirit connection” and theme 2, “Intentionality in caring-healing and wholeness” into a single theme: “Reaching out with concern to the inner life world and subjective meaning of another.” This theme was re-interpreted to become the essential theme “Dwelling with another in mutuality.” This theme emerged from the fundamental meaning “Being viewed as a whole.” The women all described experiencing this theme, “Dwelling with another in mutuality” as having a special relationship with nurses beyond
their physical presence in the women’s homes, the nurses connected in a metaphysical “felt” space in the women’s life worlds. The women’s perceptions of nurses ascribed to this theme included: showing concern for them as an individual, feeling a deeper connection beyond the nursing situation, feeling whole, and being treated like an equal. Verbatim examples from the women’s reflections are identified below to provide textual expressions of the theme “Dwelling with another in mutuality.”

Marie said, “She guided me through the situation in a caring manner. She allowed me to say how I felt. The nurse did not judge me or dismiss my feelings, she just listened and paid attention to how I was feeling.” Alethea said, “We had so much in common, it was amazing. She did everything she could to make things better. She was a very good nurse but what made me feel better was …the person she was … easy to be with.” Laela said, “She listened to me talk about my family and what was happening in my life. The nurse sensed I was uncomfortable and catered to making me feel relaxed … The pain in my legs it's getting worse from the neuropathy. She takes her time when she wraps my legs; it makes me feel so much better. … I feel like she is wrapping my spirit too.” Helen said her nurse was, “Down to earth, easy to talk to.” Helen was overwhelmed with caring for her ill husband and neglected her own health. She described her experience as, “She did not just focus on my diabetes; she looked at everything that was going on with me, including the problems with my husband. I felt so much better after she helped us. I felt like she cared and was concerned.” Ruth said, “I felt she had my best interest at heart. She doesn’t make me feel like I’m some old lady, but I matter to her. She is always very respectful.” Emma has constant pain in her legs, she said, “It was the little things she did that made me feel better, like being patient and not rushing. She treated me like an individual, it felt good to feel I had choices instead of always feeling helpless and out of control. Sometimes the nurses would
call me on the phone between visits, just to show concern. It is touching to have someone like her care.” Grace had a large wound on her foot and was embarrassed for the nurse to see the wound. She said, “Having that wound was overwhelming, the nurse took really good care of me. I felt a sense of security, knowing she took care of my wound and also took care of my emotional self. She made me feel like a whole person again. The nurse took really good care of me. She gave me that special attention and I needed it at the time, she was so respectful. She made me feel like a whole person again.” Margaret said, “I always look forward to her visits. That’s my friend. When I’m a little down, she perks me up.” Flossie said, “She was very patient and very kind. I felt good about the time we spent together, it wasn’t just the nursing. She always treated me like we were on the same level.”

However, the experience of “Dwelling with another in mutuality” varied, the women in this study perceived some nurses as uncaring. As a consequence of uncaring experiences with nurses, the women recalled feeling insignificant and disrespected. The following quotations present exemplars from the voices of the women.

Emma: “A couple of times when different nurses visited, they did not conduct themselves like nurses are supposed to. They did the job alright, but it was clear that they were just earning a pay check. It left me feeling empty, not energized like I feel when my nurse spends time with me.”

Ruth: “Some of those nurses, I don’t know why they in the nursing business. They need to sit behind a computer where they don’t have to deal with people. I can usually tell right away because they rushing. One nurse didn’t even take her coat off; she stood up the entire time, made me feel like she didn’t want to be here.”
Margaret: “I had one or two bad ones come here. No personality, don’t know how to treat people. They act like they don’t care about me as a person.”

Laela: “When she got here, she did not speak, she did not smile. All she said was are you the patient and what is the problem. Then she took her computer out of her bag. She was so cold, I did not want her to touch me or bring that negative karma in my house. So I told her I did not have a problem, she could go on to her next patient. I didn’t feel good all day.”

Marie: “What is not helpful is some nurses, even though they do all the things that they're supposed to do, they focus on the job, they don't give you that personal type of care, sometimes not even a smile. It makes me feel uncomfortable in my own house.”

The women’s recounts of their experiences ascribed two eidetic features to the theme “dwelling with another in mutuality”: a metaphysical interaction which was an emotional “felt” experience and nurses mindfully focused on the person as an individual in relation to their life world. The women frequently described feelings of: being cared about, shown concern, a special relationship, and being spiritually touched by nurses. The meaning of their descriptions was depicted as a holistic personal relationship with nurses, which was a constant and prevailing theme throughout this study. In the final analysis this holistic personal relationship has the same meaning as the essential theme “Dwelling with another in mutuality.”

**Essential Theme 2: Being an authentic presence in the moment**

I condensed preliminary theme 3, “Deepening relationships” and theme 4, “Identifying self in relation to another” into a single theme: “Authentically identifying self with another in a humanistic connection.” This theme was re-interpreted to become the essential theme “Being an authentic presence in the moment.” This theme emerged from the fundamental meaning “making
connections.” The women all described experiencing this theme “Being an authentic presence in the moment” as a time when they needed nursing care, with an authentic presence, a nurse that was humble and offered self with compassion for their sake. The women’s perceptions of nurses ascribed to this theme included: feeling connected, instilling hope, reaching out, listening and establishing trust. Verbatim examples from the women’s reflections are identified below to provide textual expressions of the theme “Being an authentic presence in the moment.”

Ruth, an amputee and is unable to care for herself independently. She did not want to live in the nursing home. She said, “I trust what she says. I know she will help me with what I need.” The ones I consider real nurses, they are wonderful.” Ruth described feeling “comforted” having the nurse call from home to see how she was doing. She said, “I can call her even when she is off and she will take time and listen and show compassion and understanding. Our connection is personal and still professional, it’s not just business.”

Emma received nursing services because her blood sugar was out of control and it was getting harder for her to manage. Emma said, “She treated me like an individual, it felt good to know I had choices instead of always feeling helpless and out of control.” Emma found meaning in the nurse not “being judgmental” and “listening.” Emma said, “She was always so pleasant and happy, it rubbed off on me. She was caring, would call me on the phone to ask if I was alright. It made me feel special”

The nurse took care of a wound on Grace’s foot. Grace said, “I called it a professional friendship because I feel connected to her. If I ever need someone to take care of me, it would be her because she cares about me. I felt comfortable. I could talk to her about more than just the health stuff.”
Alethea described her situation when she first came home from the hospital. She recalled, “I did not realize how weak I was and there was no one to help me. First of all, I did not think I would need any help. I thought I could go back to my usual routine. My daughter had to work and take care of her family. She was prepared to bring my meals and check on me. When the nurse got here, I was a mess. She knew exactly what to do and she did not leave me. She helped me wash my face and brush my teeth. She cooked my breakfast because I had not eaten. She was very supportive when I was in a difficult place and didn’t have control of my situation. I felt like I was at home with a friend who understood. I still feel a connection.”

Marie recalled feeling “encouraged” and the nurses’ words that gave her “confidence”. Marie said, “She was very caring and supportive “She listened to me. We got to know each other, we connected. She was right there with me.”

Flossie said, “No one cared about me as a person, I was just a diabetic patient to them… The nurse visited to help me with the blood sugar; it was never controlled very well.” Flossie said, “The nurse did not judge me or dismiss my feelings, she just listened.” Flossie was content at having been guided through the situation in a caring manner; she described feeling the nurse allowed her to “say how I felt.” Flossie said, “She was the best. She helped me with how I was feeling about having diabetes. If it wasn’t for her, I would still have an angry knot inside me. Now, when I think about the fact that I have diabetes, I feel grateful that I can still be healthy if I care for myself. I owe that to her, my health.”

Helen said, “I felt like I was carrying a heavy load, if I had time I could be depressed about it….I needed the nurse to manage my diabetes and help with my husband….Everything was falling apart.” Helen said, “She cared enough to listen.” Helen recalled feeling really impressed that the nurse showed such “concern” for her and her husband. Helen said, “She was
so compassionate. It was amazing. The last thing I expected was for her to be interested in what was going on with my husband, but she was, and that made life comfortable again.”

Laela lives in pain all the time. The nurse visited to teach her to self-administer insulin. Laela said the nurse was compassionate, understanding of her situation and showed “concern.” Laela said, “I was able to open up, I had not told a soul what I was going through. She made me feel like she cared about what happened to me. She made me feel at ease about my health. She was not only knowledgeable; she showed an interest in doing her best for me, to make sure that I was ok.”

Margaret is blind with cardiac disease. Margaret receives nursing services to prepare her medicines and pre-fill insulin syringes. Margaret described feeling “understood” and “respected.” Margaret said, “We have a special relationship, more of a friendship. She is very understanding, and respectful. She treats me like an equal.”

Eidetic features of the theme “Being an authentic presence in the moment” emerged from the women’s descriptions of what the nurse-person relationship was like for them and its impact on their individual lives. These eidetic features derived from their descriptions included: instilling hope and giving of self with an open heart. Reflecting on aspects of their relationship with nurses that were meaningful to them, the women described moments when they experienced nurses opening their hearts to give freely of themselves. They described feelings of being cared for, helped to feel better, adjusting to their situations, and managing illness. This was described as a sensitivity of the nurse on their behalf which supported growth in their individual situations and a sense of caring between nurse and person. The meaning of their descriptions was depicted as “instilled hope through nurse-person relatedness”, which was a constant and prevailing theme
throughout this study. In the final analysis “instilled hope through nurse-person relatedness” has the same meaning as the essential theme “Being an authentic presence in the moment.”

**Essential Theme 3: Creating opportunities for a higher level of wellness in suffering and illness**

I condensed theme 5, “Finding a deeper meaning beyond suffering”, theme 6, “Helping another to grow in the human experience” and theme 7, “Acceptance of reality and finding hope in the situation” into a single theme: “Fostering growth and self-actualization in the illness experience.” This theme was re-interpreted to become the essential theme “Creating opportunities to achieve a higher level of wellness in suffering and illness.” This theme emerged from the fundamental meanings “Transforming” and “Finding meaning.” Reflecting on the impact nurses had on their lives, the women all expressed in their narratives this theme “Creating opportunities to achieve a higher level of wellness in suffering and illness” as ways in which relationships with nurses helped them adjust to the uncertainty of aging with diabetes that improved subjective feelings of their health. The women’s perceptions of nurses ascribed to this theme included: taking time, being helpful, being patient, being compassionate, reassuring, looking past the illness, and being supportive. Verbatim examples from the women’s reflections are identified below to provide textual expressions of the theme “Creating opportunities to achieve a higher level of wellness in suffering and illness.

Emma was disappointed that the effects of diabetes on her body did not allow her to live the life she planned. Emma said, “She was helpful, we would have serious discussion about my lifestyle, which brought the reality of the situation closer to the front of my mind and made me more in tune with staying on point every day. She was involved and showed concern this encouraged me. My blood sugars are controlled now.”
Laela experiences constant pain in her legs, she said, “I don’t mind getting old but feeling old, I can live without.” Laela said, “Keeping my sugar under control means so much to me but it does not always happen that way. She was very helpful with learning to manage my diabetes. She told me to eat right after I took my insulin and why I was so important to do it that way. That was very helpful because I haven’t had any low blood sugars since I have been doing it that way.”

Flossie felt angry she was “stuck with a diagnosis” of diabetes, she could not face her diagnosis. Flossie described how a nurse helped her to accept living with diabetes after being in denial for a number of years. Flossie recalled the nurse “listened and understood how I felt.” She spoke of feeling that other health professionals viewed her as a diabetic patient while her nurse “treated me like a person.” Flossie described her anxiety surrounding living with diabetes. The nurse “touched” her and “listened” which helped her face her feelings and alleviate the anxiety. Flossie, “She gave me a lot of good ideas about how to make it better and easier for me to manage my sugar to keep it under control. She helped me live with my illness”

The importance of being understood as an individual that transcended concern for the physical body was profound as revealed in this description by Grace “When I first had the wound on my foot, I was feeling old and really down. Talking to her made me feel like I could still get out and live my life. She got to know me and looked past that big sore I had on my foot. It helped me feel more like my old self.” Grace had limited mobility and declining visual acuity. She became very serious when she described loss of familiar activities such as walking and sewing. Grace recalled her experience of being frightened “I never had a wound that big, I knew I had to get a handle on my blood sugars.” Grace said, “She gave me tips about what I could do for myself to get my wound healing better and faster, managing my weight, and the kind of shoes I
should buy.” Grace said the nurse was so compassionate and concerned she healed her body and spirit.

Ruth’s voice illuminates the value women in this study placed on nurses knowing and understanding them as unique individuals. Ruth is an amputee, confined to a wheelchair with no family in close proximity. Ruth said her body does not work anymore and she cannot function as she did when she was younger. Ruth said if it wasn’t for the nurses, she would not be able to live in her home. Her regular nurse is always available by phone even when she is not working. Ruth said the nurse,

“Takes her time and listens and shows compassion and understanding. It’s important to me that she don’t make me feel like I’m just some old lady, but I matter to her.” When asked what the nurse does to make her feel that way, Ruth said, “She doesn’t treat me like I’m a sick person. If I’m going out, she will help me pick out what I’m wearing because she knows I like to dress and wear my hats. We talk about everything, my coconut cake receipt, whatever. We share something. I know when a person is concerned and when they are not. For example, every month she has to change my catheter. Some nurses…taking it out and putting it in, is so painful I almost jump off the bed. When my nurse changes the catheter, she takes her time and is so gentle, I don’t feel a thing.”

Margaret was upset she could not go outside unaccompanied, her voice and demeanor expressed a sense of loss of control. Margaret simply said, “Sometimes, the diabetes just wins.” Margaret experiences limitations because of reduced vision and was unable to read a pumpkin pie recipe. She said, “The nurse helped her by reading the recipe and making sure the ingredients were measured correctly.” Margaret said the nurse knew her situation and understood what it meant for her to have pumpkin pie for Thanksgiving. Margaret recalled, “It felt like my family
was with me, she took time to share and spend a personal moment with me. I started baking again; I thought I couldn’t do that anymore.”

Marie revealed, “I was really struggling with the diabetes.” Marie was not able to travel on the bus anymore because she was no longer strong enough. She expressed a sense of lost independence “I don’t want to depend on anyone too much.” Marie said the nurse sensed her anxiety “No one took the time to think about how I was feeling.” Marie was anxious about self-administering insulin; the nurse was reassuring, patient and supportive. Marie said the nurse made her feel she was “not in the situation alone.” “She was very helpful with learning to manage my diabetes I feel grateful that I can still be healthy if I care for myself. I owe that to her, my health.”

Alethea cannot get around anymore because her legs hurt all of the time. She described loss of self when she said, “I feel like I lost something. Apart of me I can’t get back.” Alethea states almost as a matter-of-fact, “I try to keep my sugar under control because I have enough problems form the diabetes but sometimes, it goes up, especially if I’m stressed about something.” Alethea said,” The nurse talked to me about things I could do to stop my heart from getting worse. I have not been back in the hospital since she helped me. The nurse taught me how to be proactive not reactive when it comes to my health. She taught me what to do if my weight is up or my breathing gets worse.” Alethea described a situation in which the nurse helped her through a very sad and emotional moment brought on by her concern for future effects diabetes may have on her body. The nurse helped her manage the uncertainty by being “supportive” and “listening.”

Helen was overwhelmed trying to care for her husband with dementia, neglecting her own health. The nurse relieved her uncertainty by providing services for her husband and
helping her focus on addressing her own health issues. Helen said, “I did not know what was going to happen to us. She was so supportive. Life took on a different twist, that just means we have to do things differently and the nurse helped us figure that out.”

The women’s recounts of their experiences ascribed two eidetic features to the theme “Creating opportunities to achieve a higher level of wellness in suffering and illness” which are “knowing and understanding the person as an individual” and “sharing knowledge”. The women frequently described feelings of: being cared for, helped to feel better, adjusting to situation, and managing illness. The meaning of their descriptions was depicted as improved subjective feelings of health which was a constant and prevailing theme throughout this study. In the final analysis this improved subjective feelings of health has the same meaning as the essential theme “Creating opportunities to achieve a higher level of wellness in suffering and illness.”

**Essential theme 4: Developing trust in a loving and compassionate human-to-human connection with another**

I condensed theme 9, “Reaching out to another transcending self”, theme 10, “Offering love and compassion” and theme 11, “Forming a trusting relationship beyond the boundaries” into a single theme: “Being with another in love and compassion, beyond the boundaries.” This theme was re-interpreted to become the essential theme “Developing trust in a loving and compassionate human-to-human connection with another.” This theme emerged from the fundamental meanings “Offering self with an open heart” and “Going beyond.” The women all described experiencing this theme “Developing trust in a loving and compassionate human-to-human connection with another” as a humanistic relatedness in which nurses showed sensitivity to their situations beyond expectations. The women’s perceptions of nurses ascribed to this theme included: a personal connection, being open, emotional involvement, a shared experience
and going out of the way. Verbatim examples from the women’s reflections are identified below to provide textual expressions of the theme “Developing trust in a loving and compassionate human-to-human connection with another.”

Marie said, “She was patient. She came every morning to make sure I got my insulin. She took her time with me and I felt like I was her main concern. She listened to me talk about my family and what was happening in my life.” Grace described her relationship with the nurse, she said one day when she was “feeling really down.” Grace said, “She put her arms around me and wiped my tears. I feel so blessed that she was here to take care of my wound. It’s hard to put in words, it’s like going to church, and something stirs inside you and makes you feel like a better person for having that experience. If I ever need someone to take care of me, it would be her because she cares about me. When I was at my lowest point, she listened to me and treated me like I was her sister instead of a patient.”

Margret said this about her nurse, “She’ll pick me up something if I need it, especially if it’s somewhere hard for me to get to. She is someone I can call on. I know I can put my life in her hands because she cares about me. That’s my special friend.” Margaret continued “Some of those nurses get on my last nerve. The other nurses, like the one that has been with me for the past four years, I have to applaud them because they go out of the way. To be truthful it is a little scary not being able to see and my daughter lives out of state.” Margaret said her nurse makes sure that things are in place so she does not have problems. She said, “Not only making sure I have transportation and medications, I know she is there for me and I can call her for anything. It’s like I do have family close by.” Flossie felt, “I know she doesn’t do it for the money because she gives you herself and money can’t buy that.” Alethea said her nurse always “She was like family to me; I never thought someone I did not even know would show me so much love. She
always took that extra step to help me.” Helen felt, “She was so caring; it meant the world to us. She looked at our situation and actually made it better, beyond what I expected.” Laela said, “My nurse spent time to understand what it was like for me living alone with my health problems and helped me get situated at home. … This made living alone a safe situation. …I don’t think she would have cared more for me if I was her mother.” Ruth said she depends on her nurse who shows concern and “goes out of her way to make sure everything is correct.” Ruth feels a connection to the nurse that is “personal and still professional, it’s not just business.” Emma recalls an experience when a nurse picked up her medicine from the pharmacy, “So I would not miss a dose.” She said, “She gave me that extra attention… she was involved and showed concern.”

Eidetic features of the theme “Developing trust in a loving and compassionate human-to-human connection with another” derived from the women’s experiences included: “Empathetic attendance” and “Going beyond”. The women frequently described feelings of: genuineness, warmth, compassion, being fully engaged, trusting relationship, and beyond anticipation. The meaning of their descriptions was depicted as honoring another unconditionally which was a prevailing theme throughout this study. In the final analysis, honoring another unconditionally has the same meaning as “Developing trust in a loving and compassionate human-to-human connection with another.”

**Interpretive Statement**

An interpretive statement unifying the essential themes in this analysis was created to illuminate the lived experiences of BW aging with diabetes cared for by nurses in their homes. It is represented by, “Being in the moment with another in authentic presence; while dwelling and creating opportunities to achieve wellness by transcending suffering and illness through love and
compassion in a human-to-human connection.” The women’s experiences in the nurse person
caring-healing relationships from the perspective of their life worlds are sufficiently captured in
this statement. These experiences captured in the interpretive statement were integrated and
uncovered the meaning of the lived experience of BW aging with diabetes and their perceptions
of caring relationships with nurses.

Summary

This chapter discussed the findings of the lived experience of BW aging with diabetes
and their perceptions of caring relationships with nurses that cared for them in their homes using
van Manen’s phenomenological methodology. The study participants, descriptions of their
experiences, research setting, analysis, essential themes and concluding interpretive statement
were described to illuminate and contextualize their experiences. The experience of each
participant was described from their narrative stories articulated to the researcher.

I reflected on individual statements and the fundamental meanings of aging with diabetes
and their perceptions of nurses caring to derive the themes and meanings which emerged from
their narrative stories. Transcripts of the narratives were reflected upon for redundancy and
saturation. Redundant themes and meanings were condensed to derive the fundamental meanings
of the phenomenon. Eleven preliminary themes emerged from reflection on the fundamental
meanings. Supplementary reflection upon the preliminary themes guided the creation of four
interpreted themes, which were further developed into essential themes. From these essential
themes, the interpretive statement was created to describe the phenomenon of BW aging with
diabetes cared for by nurses in their homes.
CHAPTER VI

Reflections on Findings

This chapter begins with a summary of the research and then discusses the findings of interviewing BW aging with diabetes that were visited by registered professional nurses in their homes. The findings reflect the relevant literature to the four essential themes of compassionate competent nurse-person relationships. These are presented along with excerpts of the participants' experiences that enhance understanding of this phenomenon. Next, I will describe the study's limitations and implications. There are several implications for compassionate competence theory for nursing practice, education, and further research. The chapter culminates with concluding thoughts.

The results of this study are situated within the analytics of Halldorsdottir’s (2008) theory “The dynamics of the nurse-patient relationship”, which now has an expanded version, “Nursing as Compassionate Competence” theory (Halldorsdottir, 2012). This theory elucidates the meaning of BW experiences aging with diabetes and their perceptions of relationships with nurses that visited them at home. The theory encompasses six principle factors of professional nursing care including: caring, competence, wisdom, attentiveness, empowering communication and connection. Each of the six factors is essential and professional nursing care is incomplete if all the factors are not included. Compassionate competent nursing care is experienced when patients perceive nurses as both knowledgeable of nursing care processes and practices and engaging in the human-to-human connection.

Compassionate competence is the center of professional nursing care which can be measured based on the patient’s perception of the nurse-person relationship experience (Halldorsdottir, 2012). Measurable effects of this relationship experience can be perceived as
caring or uncaring and also influence a person’s health and healing process (Halldorsdottir, 2008). For example, the highest quality relationships are perceived as connectedness and may greatly empower the person to achieve a higher level of wellness. Conversely, lower quality relationships are perceived as disconnectedness and leave the person feeling disempowered and broken.

Halldorsdottir (2012) recommended that further nursing inquiry is needed in understanding the nurse-person relationship from the person’s perception and how this perception may influence health and healing. This study makes some important and interesting contributions to the profession regarding insight into the lived experience of aging BW with diabetes perceptions of nurse-person relationships. Limited research on person’s perception of nurse-person relationships and its influence on health and healing presented a challenge in studying this phenomenon. Hence findings of this study may contribute to nursing inquiry on the nurse-person relationship from the patient's perspective.

The main finding of this study is the primacy of the person’s perception of the nurse-person relationship for healing and well-being. Aging with diabetes is a challenge and many complications of the disease are associated with declining health. The participants recounted a culmination of suffering, loss of health and independence, as well as loss of connectedness and required nursing care at home. The findings of this research study support and further explicate the nurse-person relationship as the foundation of nursing and its contribution to improved health and well-being. The women’s vivid stories resonate with a sense of improved well-being when they reflected about their experiences in nurse-person relationships with compassionate competent nurses. They all recalled situations and particular moments when healing occurred through empowering communication and mind-body-spirit connectedness. The women all
reflected upon how compassionate competent nursing care improved their lives over time. There are four essential themes that emerged from the compassionate competent nurse-person relationship. These themes culminated with an interpretive statement that describes the experience.

**Essential themes**

The interpretative statement of the lived experience of BW aging with diabetes and their perceptions of the nurse-person relationship is, “Being in the moment with another in authentic presence; while dwelling and creating opportunities to achieve wellness by transcending suffering and illness through love and compassion in a human-to-human connection.” This statement emerged from integration of the four essential themes and represents the meaning of the lived experiences described by the women. The women described experiences inclusive of each theme as a constituent of the nurse-person relationship.

**Synthesis of Data and Literature**

**Dwelling with another in mutuality**

To dwell in mutuality is a metaphysical felt phenomenon, transcending physical space (van Manen, 1997/1990). To dwell is “to remain at peace within the free, the preserve, the free sphere that safeguards each thing in its essence” (Heidegger, 1971 p. 327). According to Levinas (1969) dwelling is an emotional state of peace or contentment. The women’s accounts of their experiences supported a sense of contentment with their life worlds when they were dwelling with nurses in mutuality. They described their experience as transcending the boundaries of suffering and illness.

The women in this study all described this theme “dwelling with another in mutuality” as a mindfulness of nurses that entered their homes which was consciously directed at “being
viewed as a whole”. The women’s reflections centered on nurses reaching out, showing concern beyond their physical care needs, and being engaged in a mind-body-spirit connection.

Connecting with nurses increased the metaphysical dimensions of the women’s life worlds and gave them a sense they were concerned for and cared about. This real sense of concern and care by the nurses was described as an emotional experience that improved well-being. In general, this experience of “dwelling with another in mutuality” was described as a deeper “felt” connection. Mutuality was experienced as nurses created real opportunities for active participation in the care process, empowering the women to take responsibility for self-care whenever possible. This study reveals that person’s perceptions of nurse-person relationships and the experience of mutuality emerge not so much from doing, but instead from being mindful and respectful of the person as a unique individual worthy of love and compassion.

**Being an authentic presence in the moment**

Within the experience of aging with diabetes and being cared for by a nurse at home, the participants described: their declining health, how they spent time with the nurse, and the connection they made with their assigned nurse. The theme “Being an authentic presence in the moment” is a reflection of experiences as told by the women when they connected with a nurse at a particular time in their lives. The particular time or “The moment” is a unified and dynamic interplay between three dimensions, past, present and future. It informs the meaning the nurse-person relationship holds for each person (Heidegger, 1962/2008). For the women in this study, it refers to the meaning of aging with diabetes at a particular time in life and requiring nursing care that influence perceptions of the nurse-person relationship experience.

The women described experiences in which nurse’s authentic presence diminished feelings of being overwhelmed toward having trust and positive expectations for well-being.
This is an aspect of the compassionate competent nurse-person relationship phenomenon (Halldorsdottir, 2008). Through authentic presence, the nurse is in touch with another’s life world and becomes more authentically human, and open to another's experiences. The women described “being understood” and "cared for" as a "human being". This study reveals that in situations where people feel vulnerable and in need of nursing care, they desire a nurse who exhibits authentic presence and accepts the invitation to connect. Halldorsdottir (2012) suggests that being an authentic presence involves attentiveness to the meaning an experience holds for a person in a particular situation and connecting to the person in a way that honors them with compassion. Halldorsdottir’s view is consistent with this theme as it emerges from the women’s descriptions of relationships with nurses as “compassionate”, “understanding of their situations”, and “feeling connected”.

According to Mayeroff (1971), hope is “a present alive with possibility (p. 32).” In order to care, it is essential to know what a person needs and have the ability to respond appropriately to those needs. According to van Manen, “Through hopes and expectations, we have a perspective on life to come” (van Manen, 1997, p. 104). In connecting to the person with authentic presence, nurses instill hope; this is consistent with the meaning of hope described by Hammer, Mogensen & Hall (2009). Through the lived experience of connecting with authentic presence, caring nurses evoke new possibilities for hope at a particular moment in a person’s life world that transforms and transcends time and space.

The lived experience of connecting with authentic presence infers being present with an open heart. This was supported by findings from Papastavrou, Charalambous, Tsangari & Karayiannis, (2012) and described as nurses being present with an open heart “being open”, “trusting”, and “reaching out”. Having an open heart was described as an intuitive sense of
knowing that the nurses cared for them. Authentic presence was an aspect of the nurse-person connection “Being an authentic presence in the moment” is experienced as nurses being present with an open heart, sensitive to the person’s situations and emerges from a nurse-person connection that is built on trust and creates new possibilities of hope.

Creating opportunities for a higher level of wellness in suffering and illness

As human beings, the body is our particular point of reference to the world and access to the world is gained through the body (Merleau-Ponty, 1962). While people experience illness within the social and cultural context of their life worlds, it is primarily a lived body experience of suffering and limitation (Bickenbach & Schmitz, 2014). The women in this study described aging with diabetes as a bodily experience of physical decline. In addition to living with changing embodiment, they were also challenged with social isolation, loss of self, uncertainty, loss of control, loss of independence and disruption of their familiar way of being-in-the-world. Reflecting on the women’s human experience of aging with diabetes this theme, “Creating opportunities for a higher level of wellness in suffering and illness” illuminates their perception of ways in which nurses were dynamically involved in improving their subjective feelings of health. The women described nurses involvement as” being helpful”, “being supportive”, “looking past the illness”, and “reassuring”.

The women perceived nurses as knowing and understanding them as individuals, engaging them in their personal situations. This engagement occurred as nurses explored perceptions, beliefs, and priorities with the women evoking and exploring the meaning of the illness experience. Through exploring meaning of their individual and unique challenges, new meanings of their experiences emerged that significantly altered the ways they viewed themselves in relation to being-in-the-world. This new view involved finding a deeper meaning
beyond suffering through being able to accept reality and find hope in their situations. The women all related that with the guidance of their nurses they experienced a change in self and felt free to choose their own way in the illness experience. This theme is an integral component of the nurse-person relationship phenomenon and illuminates the value of that relationship as fostering growth and self-actualization in illness by transforming perceptions of the illness experience.

Transforming perceptions was described by the women as a "managing uncertainty", "figuring it out", “making a difference”, “living my life”, and "living with my illness”. For these women who could not change the realities of aging with diabetes, they found meaning through nurse-person relationship and transformed themselves. It is in this transformation that healing occurs. For the women, transforming was a change in perception of self in relation to being-in-the-world that allowed an improved sense of well-being. Healing occurred not only in the physical aspects of embodiment, but as a holistic phenomenon in each woman’s transformation in suffering and illness. This experience was a prevailing theme throughout the study.

Insights from Compassionate Competence Theory of Professional Nursing care (Halldorsdottir, 2012) enrich the meaning of professional nursing care as a mind-body-spirit experience in which persons can grow under any condition. The aim of nursing is to place the person in the best possible state of health, by fostering a relationship which empowers the person (Halldorsdottir, 2008). When both nurse and person connect authentically as people first, the potential for the person’s emotional well-being, trust and comfort level with nurse’s will increase. Although some nurses are concerned with professional boundaries and being overly ‘friendly’ with people they care for (Halldorsdottir, 2008), the women in this study appreciated a closer personal connection beyond the professional relationship.
In this study, “Creating opportunities for a higher level of wellness in suffering and illness” refers to nurses’ assisting individuals to find meaning in the illness experience there by facilitating growth and self-actualization. When engaged in nurse-person relationships, the nurse facilitates the healing process and helps promote autonomy and positive change within the person (Fitzpatrick & Whall, 2005). The women described experiences in which nurses supported them to maximize their potential for healing and well-being. They described the relationship between nurse and themselves as an experience that involved feelings that were matched with professional knowledge, competence, and skilled nursing care. The nurse provided holistic care to meet each individual woman’s needs. The women described the feeling that the nurses attended to their unique needs when they were most vulnerable and needed care. In the lived experience of vulnerability, the theme “Creating opportunities for a higher level of wellness in suffering and illness” was derived. Here the women’s descriptions included: knowing and understanding the person as an individual and sharing knowledge. This study reveals that the person’s perceptions of nurse-person relations may assist in regaining control of an altered life course and the development of positive psychological responses to illness within the context of aging with a chronic disease.

**Developing trust in a loving and compassionate human-to-human connection with another**

This is the dominate theme in this study, threading through all other themes, the human-to-human connection is most prevalent and central in the women’s descriptions. The women expressed this human-to-human connection as the experience of “openness”, “emotional involvement”, and “personal connection” wherein they felt love and compassion from nurses. In this theme, the women perceived the nurse-person connection as nurses giving of themselves, showing sensitivity to the human condition beyond expectations. In caring for others, nurses
relinquish their egos with unselfish love and compassion (Mayeroff, 1971). This is best described by the women as nurses “offering self with open heart”, which evoked feelings of being loved and cared for by the nurse.

The women all described meaningful relationships with nurses that honored them in their unique situations and assisted them to better understand their intersubjective self in the midst of experiencing loneliness, suffering, isolation, and aging with diabetes. The women’s reflections highlighted encounters with nurses that focused on human-to-human interconnectedness and also their personal experiences to improve well-being. The women described experiences with nurses’ being in empathetic attendance. This was expressed as nurses being sensitive to their feelings, thoughts, and life world situations. A prevailing theme in the study was the women’s experience of nurses’ unconditional ways of being. This was seen as an intersubjective human process that influenced their perception of nurse-person relatedness.

In this study, the women repeatedly verbalized the importance of nurses not judging them. They described enhanced feelings of self when nurses treated to them as equal human beings. The women recalled “feeling validated”, “nurse’s being sensitive”, and “not judging”. When nurses were nonjudgmental and openhearted, this was experienced as “Transcending self-offering love and compassion”. Here the trusting relations between the women and the nurses were formed. The women communicated trusting nurse-person relations as feelings of “mutual sharing and trust”, “being engaged in a relationship”, “connectedness”, “concern”, “respect”, “being treated as an individual”, and “understanding”. Levinas (1968/1996) proposes this is an obligation in caring and respect towards another.

Through the lived experience of forming respectful and trusting connections with nurses, a deeper human-to-human connection was possible. A universal essence in this study was the
women’s perceptions of an emotional shared experience in the nurse-person relationship they described as “going beyond”, “going out of the way”, and “more than expected”, or “imagined”. According to van Manen (1997/1990), we maintain relationships with others in our shared interpersonal space. In other words, we become who we are through relationships with others. For the women, this experience with the nurse was one of forming trusting relationships beyond the boundaries through which their life worlds were strengthened and personhood affirmed.

**Thematic Statement Reflection Using a Nursing Model**

The aim of this study was to describe the lived experience of BW aging with diabetes and their perceptions of relationships with nurses that visited them at home. The findings of this study revealed four themes that were synthesized into the interpretive statement: Being in the moment with another in authentic presence; while dwelling and creating opportunities to achieve wellness by transcending suffering and illness through love and compassion in a human-to-human connection. This interpretive statement suggests that the dynamic interplay between nurse and person, a powerful energizing force that constitutes more than the physical presence of the dyad. This energizing force potentiates change in the participants’ perceptions of self, all which influence their health and well-being. For this study, I choose to relate the nurse-person caring-healing relationship to the “Nursing as Compassionate Competence” theory (Halldorsdottir, 2012). The intent was to foster a more open stance in examining the persons’ perception of lived experience of caring in view of the dynamics of the nurse-person relationship.

I selected Halldorsdottir’s “Nursing as Compassionate Competence Theory” because of its pragmatic, relational, holistic, spiritual and humanistic views that embrace and explore the art and science of nursing. The essential themes of the nurse-person caring-healing relationship phenomenon are described through the lens of nursing as Compassionate Competence Theory to
illuminates the findings of this study in relation to existing nursing caring science literature. The findings from this study will contribute to the knowledge of the art and science of nursing. The central tenet of Compassionate Competence Theory is “caring is the heart of nursing fueled by genuine concern and love”, (Halldorsdottir, 2012 p. 7). This theoretical work has specifically articulated the importance of the person’s perception of caring nurse-person relations as a factor in health and healing (Halldorsdottir, 2012).

Halldorsdottir’s theory advances the reciprocal-interaction-caring paradigm by focusing on the concept of compassionate competence (relational connection and professional expertise) to view the nursing metaparadigm concepts: nursing, health, human being, and environment. Within Halldorsdottir’s (2012) theory these concepts are defined as: nursing, an autonomous scholarly discipline with its own objectives and specialized service, provided through the nurse’s (human being) compassionate competence; the patient, a person (human being) with integrated mind, body and spirit within a family and community; health, a multidimensional subjective person condition; and the environment, the context of the person both internal and external. The person (patient) is empowered by the person (nurse) increasing well-being allowing them to better cope with their situations.

Concepts of “Nursing as Compassionate Competence” Theory that specifically inform and correlate with the lived experience of the caring-healing relationship phenomenon are the nurse and person (human beings), creating opportunities to achieve a higher level of wellness in suffering and illness (health), transcending self-offering love and compassion to another in the human-to-human connection (nursing), and being an authentic presence in the moment (environment). The nurse-person caring-healing relationship is the intersubjective transpersonal
conscious experiences in which nurses with intentionality focus on human capacity to assist persons achieve their highest level of wellness.

Nursing as Compassionate Competence Theory was developed to serve as a structure for understanding nurse-person relationships (Halldorsdottir’s, 2012). This latest rendition significantly builds the theory by defining the major concepts within the nursing metaparadigm; it also contributes to the definition of nursing and the art and science of professional nursing care. This version contributes to the definition of nursing by articulating six main assumptions that comprise compassionate competence, they include: caring, competence, wisdom, attentiveness, communication and connection, and self-development of the nurse. These assumptions are constructed to inform what constitutes good care from the perspective of persons receiving nursing care. Communication and connection are foundational assumptions in that nurse-person relatedness is the experience in which nursing care occurs; and through this interpersonal relationship health and healing are influenced (Halldorsdottir, 2008). The nurse-person relationship phenomenon was reflected upon using this theory due to congruency of the concepts as they relate to perceptions described by the women in this study.

Table 3: Shared Essential Elements of nurse-person caring-healing relationship and Compassionate Competence Theory

<table>
<thead>
<tr>
<th>Shared Essential Elements</th>
<th>Nurse-Person Caring-Healing Relationship</th>
<th>Compassionate Competence Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Beings</td>
<td>Nurse and person connection</td>
<td>Person (patient) is empowered by the person (nurse)</td>
</tr>
<tr>
<td>Nursing</td>
<td>Transcending self-offering love and compassion to another in the human-to-human connection</td>
<td>Autonomous scholarly discipline with its own objectives and specialized service, provided through the nurse’s compassionate competence</td>
</tr>
<tr>
<td>Health</td>
<td>A higher level of wellness in suffering and illness</td>
<td>A multidimensional subjective person condition</td>
</tr>
<tr>
<td>Environment</td>
<td>An authentic presence in the moment</td>
<td>Context of the person both internal and external</td>
</tr>
</tbody>
</table>
Concepts of Nursing as Compassionate Competence Theory (Halldorsdottir’s, 2012) address the person’s perception and are congruent with the essences in this study include: caring, the heart of nursing; nurse’s competence within the professional domain; nurse’s wisdom, the interplay of knowledge and experience; nurse’s attentiveness, reception, alertness and awareness of the person; and nurse’s empowering communication and positive connection, perceived as caring or uncaring. These concepts are reflected in the essences of the nurse-person relationship phenomenon in which nurses form transpersonal relationship based on respect and love for the person to empower growth in the human situation. Further congruence is evidenced by Halldorsdottir’s perspective of compassionate competence as a way of nurse’s being with and attending to persons in their care, affirming a humanistic connection, through nurse-person relatedness where nurses’ authentic use of self transcends the physical realm in the mind-body-spirit interaction. These similarities are attributed to interaction and humanistic foundations of the Compassionate Competence Theory consistent with findings of this study.

Participants in this study described their experiences of relations with nurse’s that visited them at home as nurse’s offering self with sincere intentions and empathetic understanding and concern transcending physical space, connecting on the emotional and subjective realm. At times, this was difficult for the women to articulate. However, the participants provided rich descriptions of their experiences in nurse-person relationships that allowed them to move towards a more enlightened sense of self that improved well-being and captured their lived experiences.

**Limitations of the Study**

This phenomenological qualitative research study explored the lived experiences of BW aging with diabetes and their perception of nurse-person caring-healing relationship had
limitations. This study, as any qualitative study, is not generalizable as findings are limited to the experiences of the women within the context of this study. This factor may potentially alter the experience and perceptions nurse-person relationships.

Another limitation of this study is the setting in which the nurse-person relationship phenomenon was experienced. All 9 participants are women in a community setting of a large metropolitan city that received nursing care at home. Nursing care provided in the women’s homes may account for a different perception of the nurse-person relationship as opposed to being cared for in other healthcare settings such as an acute care or long term care setting.

The third limitation was the research study only included interviews as data sources. The interviews limited the type of data collected from the participants to oral descriptions and statements and did not allow for the participants to be observed interacting with the nurses in their homes. While the semi-structured interviews provided the participants the opportunity to explain fully their perceptions of the nurse-person relationship in their own words and experiences, utilizing different forms of data collection could provide further insight into the this phenomenon.

Another limitation is the research findings are specifically relevant to the unique demographic of this study. They are only relevant to BW aging with diabetes. This specific demographic information is useful and supports the findings to establish a better understanding of nurse-person relationships. However, other races and genders were not included in the research study; therefore, the findings do not relate to those demographics. The women in this study were English speaking BW residing at home and living with complications of diabetes. The perspectives of males or persons who did not speak English were not obtained and those viewpoints may have provided further understanding of the experience of aging with diabetes
and perceptions of the nurse-person relationship. This is a limitation because nurses care for all persons regardless of gender or race. Obtaining descriptions from participants of different ethnic backgrounds and cultures could further illuminate the meaning of the study phenomenon.

**Implications**

**Discipline of Nursing**

This study compels nurses to reflect on people’s perceptions of nurse-person relationships. What truly matters to the women in this study is caring in the human-to-human connection. This study contributes to explicating essences of the person’s perception of the nurse-person relationships within a nursing context. Each person’s perception of nursing caring and being cared for by nurses has meaning related to their culture and situation (Suliman, Welman, Omer & Thomas, 2009) which has implications for transforming nursing theory development, research, practice, and education.

This is one of the few studies that explored the lived experiences of aging BW with diabetes nurse-person relationships from the person’s perspective. This researcher had the opportunity to hear stories from the women about their experiences with nurses that cared for them in their home. These experiences, as told by the women, provided a better understanding of what it is like aging with diabetes in need of nursing care.

The aim of phenomenological research is to create meaning and expression of the lived experience through reflection (van Manen, 1990). This research study uncovered the meaning of aging black women with diabetes nurse-person relationships. Understanding the relation to the person’s perceptions of caring and uncaring adds to the development of personal nursing knowledge by describing and uncovering specific awareness, the moment in the context of
human-to-human interaction. This shared human experience allows for the identification of nursing actions (Halldorsdottir, 2008).

The structure of the meaning of the lived experience of aging black women with diabetes perceptions of nurse-person relationships has implications for the discipline of nursing. Critical reflection on this study's theoretical basis calls for examining nursing's theoretical and tacit knowledge of human-to-human relating and how that may be perceived as caring or uncaring and broader implications for health, healing, and well-being. Historically, nursing's views on human-to-human connection have assumed linear nurse-patient relationship over time, defined human-to-human relations as a procedure or technique, and left the meaning of rich human experiences unarticulated.

Information gained in this research study may aid nurses who care for people aging with chronic diseases to develop and cultivate nurse-person relationships. This knowledge may allow a deeper understanding of the phenomenon and give insight into another’s experiences. While each person’s experiences can be unique sometimes it may be possible to identify similarities. In this study, the identification of similarities aided in the understanding of what it is like for people aging with a chronic disease in need of nursing care. These similarities may be helpful for nurses to recognize what people perceive as caring and uncaring to better establish human-to-human relationships.

The theoretical conceptualization for this study was, “Nursing as Compassionate Competence Theory” (Halldorsdottir, 2012). This theory was selected based on congruence with nursing science from the view of the nurse-person relationship phenomenon; it also explores perceptions and meaning in the context of human-to-human connections. The essence of the lived experience of BW aging with diabetes and their perceptions of nurse-person relationships is
consistent with the ontology, as well as the epistemology of nursing care science. This is exemplified by describing this phenomenon from the perspective of Compassionate Competence which challenges traditional views of reductionistic nursing practices and illuminates the importance of the person’s perceptions of nursing care. From the meaning of the lived experience of aging black women with diabetes perceptions of nurse-person relationships, as depicted in this study, this relationship is not an esoteric concept that can be dismissed or ignored. It is a way of being that occurs in the human-to-human connection and has meaning for the human experience in health, healing, and well-being. This study begins to generate understanding of the unique perspective of individuals and how that articulates meaning for the art and science of nursing.

**Nursing Education**

The meaning of the lived experience of aging black women with diabetes perceptions of nurse-person relationships has implications for nursing education. In listening to and exploring the women’s description of their stories, this researcher believes that lessons can be learned and provided to nursing students and novice nurses. Even though current nursing curriculum provides didactic and clinical instruction regarding care of people in community settings with chronic diseases, additional instruction may inform students how to better engage in nurse-person relationships. From the findings of this study knowledge was gained regarding the nurse-person relationship, the influence of that relationship on person’s perceptions of caring and uncaring nurses, bringing to light the knowledge that needs to be provided to nursing students and novice nurses.

The goal of nursing education is to provide students and novice nurses with the knowledge, attitudes, and skills required to ensure the provision of quality nursing care.
Including the ethic of care in nursing curriculum is fundamental in providing quality care. “Higher education needs to educate people in every field who have ethical autonomy and the courage to act upon it—who possess knowledge, skill, and the highest values of their vocations” (Palmer, 2007, p. 12). Halldorsdottir (2012) offers guidelines for including the value of caring in nursing education and threading the person’s perceptions of feeling cared for by nurses throughout nursing curriculum. Those curriculum development threads should include the 6 assumptions of compassionate competence to provide a clear conceptualization of what caring in nursing education is and how it may be conveyed to students.

Nursing curriculum traditionally focuses on health promotion and maintenance and provides limited guidance in developing transpersonal relationships. Watson (2012) addresses the importance of transpersonal relationships that honor the meaning of the teaching-learning experience beyond didactic context. She further suggests that through curricula focused on developing nurse-person relationships nursing education is advanced which can expand the humanistic perspective in nursing science.

Nursing education offered from a reciprocal-interaction-care paradigm is foundational for teaching the holistic perspective of the meaning of nurse-person relationships. From this perspective, knowledge about the meaning of the lived experience can be grasped, illuminating the values embedded in the paradigm. This study of BW aging with diabetes and nurse-person relationships supports the value of nourishing the development of nursing student and person relationships through nursing curriculum. This knowledge may allow for a deeper understanding of the attitude and skills that should be developed in novice nurses and nursing students to ensure the people they care for perceive them in a healing light (Halldorsdottir, 2008).
Nursing Practice

The meaning of the lived experience of aging black women with diabetes nurse-person relationships has implications for nursing practice. This study affirms Halldorsdottir’s (2012) beliefs about nursing as a mode of communicating and being with the person which sensitizes a person’s perceptions of caring and uncaring nurses. Understanding the person’s perceptions enriches nursing practice and places the nurse-person relationship at the heart of nursing. From this perspective, the person’s perception impacts health and healing and influences well-being. Nursing practice guided by the essences of the meaning of the BW aging with diabetes and nurse-person relationships impacts nursing care as experienced by individuals. Guided by this research, nurses in practice recognize that engaging persons in their situations is imperative in the delivery of nursing care. That well-being can be experienced in the midst of suffering and illness requires a nurse-person connection. This connection is dependent on nurses giving of themselves and engaging in ways that support wholeness and provide affirmation of another.

This research sensitizes nurses to ways to invite connection through authentic presence. It divulges that personal connection may not be unprofessional, but can be foundational for nourishing support and trust, processes essential to experiencing perceptions of nursing care. The nurse-person relationships, then, fosters quality human relating which affects well-being. As previously indicated in this study, nurses bear witness to the lived experiences of people aging with a chronic disease that is filled with physical decline and isolation. Such decline involves transitions requiring changes in relating the world in which they live. Nurses engaged with persons in compassionate competent relationships provide a way of relating to the person's wholeness during times when confronted with physical decline and social isolation.
Knowledge gained from this study will provide reasoning and substantiate practices in nursing, increasing knowledge and understanding of person’s perceptions of nurse-person compassionate competent relationships. It was revealed that in learning about the women’s lived experiences many similar themes emerged deepening the understanding of the events surrounding their perceptions of nurse-person relationships. These themes incorporated actions, feelings, relationships, and spirituality as well as “meaning making” of their lived experiences. Preservation of the women’s dignity and well-being lead to the conclusion that when the nurses are perceived as caring, the potential for healing and improved well-being is present.

**Nursing Research**

This study of the lived experience BW aging with diabetes and their perceptions of compassionate competent relationships with nurses that visited at home have implications for nursing research. van Manen’s (1997/1990) phenomenological research method, as applied in this study, contributes to grasping an understanding of the person’s perception of nurse-person relationships in nursing science. Consistent with its human science base, this approach guided the unfolding of the phenomenon to provide a more open stance for examining the nurse-person relationship for persons aging with a chronic disease cared for by nurses at home. Limited studies were found in the literature search that explored this phenomenon. Both quantitative and qualitative research methods may be employed to conduct further research in exploring this phenomenon to add to nursing literature and enhance understanding. Quantitative studies that measure person’s perceptions of caring and uncaring nurse-person interactions are needed to further identify and cultivate compassionate competent nurses.
**Reflections of Researchers Experience**

This researcher’s experience listening to BW tell their stories of aging with diabetes and describe their relationships with nurses that cared for them at home enriched my understanding of the circumstances aging with a chronic disease. Findings from this study helped to understand how people perceive nurses as caring or uncaring. The women told their stories of experiences with nurses that cared beyond expectations that honored not only the women but the nursing profession. Some of the women became visibly emotional during the interviews, which I did not expect. These emotions expressed the lived experiences of connecting in nurse-persons relations that honored and promoted an improved sense of well-being.

This researcher garnered various insights from van Manen’s approach to inquiry. For example, the participant’s narratives were very beneficial in facilitating the thematic analysis. Sharing the narratives with the women not only affirmed the researcher's perspective, but also intensified the connection with the participant. Since the intent was to involve the participant as a co-investigator, the participants offered other information which further enriched the researcher's understanding of the phenomenon. The researcher perceived this sharing as evolving from the participants' awareness of and reflection on the phenomenon as they engaged in the dialogue and revealed their experiences.

The transformation of data from the participant’s narratives of their experiences to fundamental meanings and preliminary themes was fairly easily accomplished. In contrast, the process of formulating interpreted themes and essential themes and the creative conceptualization of the essential themes into an interpretive statement was an intense process which required much reflection and time. From this approach to inquiry, the researcher gleaned the following insights relevant to nursing inquiry: people are sources of knowledge about nurses
and nursing; and phenomenological research method generates knowledge of the lived experience that can be meaningful to both nurses as well as people in their care. Knowledge generated from phenomenology research methodology can uncover the meaning of lived experience, contribute to advancing nursing theory, more fully illuminate nursing's domain of inquiry, and inform nursing practice.

**Recommendations for Further Study**

This study provided information within the lived experience of aging black women with diabetes cared for by nurses at home. The information generated from this study may be used for studies within other patient populations. Studies may be done to explore the themes derived from the experiences of the women. Moreover, further studies may focus on persons of diverse cultural backgrounds and gender differences in varied populations. This particular study included only female participants, results of subsequent studies may be compared to the findings presented here.

Additional research studies are needed to add to further knowledge development as it relates to nursing science of nursing care and nurse-person relationships. Theoretical clarification on the construct of nurse-person relations will direct inquiry and understanding of the person’s perception of caring and uncaring. The person’s perceptions of nurse-person relations may also be studied within the context of other settings and health care disciplines.

The nature of phenomenological research lies not in finding answers, but, rather, in raising awareness and questions about the meaning and value of certain phenomena. As responses to questions are summoned, further questions unfold in the course of the answering. Through this process, meaning and, then, understanding emerge. Such understanding evokes further query from which recommendations evolve. This study of the lived experience of aging
with a chronic disease and the person’s perception of nurse-person caring-healing relationships incites awareness of a numerous of issues for further inquiry. The following recommendations are offered.

- Include children, adolescents, and varied aged populations in further investigations of the phenomenon of nurse-person relationships.
- Explore cultural variations of the meaning of the nurse-person relationships phenomenon.
- Further study nursing perspectives on the experience of nurse-person relations in nursing contexts.
- Investigate the effects of nurse-person relationships on quality of life and cost effective care.
- Research the use of caring and uncaring experiences as teaching approaches to sensitize students to lived experiences.
- Develop knowledge about the value of humor in nurse-person relationships in nursing contexts.

**Summary of Chapter**

Chapter VI compared the research findings with established literature. Themes where compared to other research studies to collaborate findings and secure meaning in what the participants revealed. A thematic interpretive statement of reflection using a nursing model was discussed as well as presentation of the thematic model, the limitations of the study, and reflection of the researcher’s experience. Recommendations for further study were examined to encourage further knowledge on the lived experiences of aging with a chronic disease and the person’s perception of nurse-person relationships.

This study describes the essences of person’s experiences in the nurse-person relationship that are significant for nursing practice. Here, a new view of human-to-human relating is revealed. This view provides a contextual perspective of the nurse-person relationship which is
holistic, rather than compartmentalized. Furthermore, it explicates that the relationship develops from love and authentic connection and is experienced as life transforming. The women all described ways in which those nurses impacted living with physical disabilities and declining health caused by the disease. From a phenomenological perspective, it articulates the meaning of the lived experience of the nurse-person relationship within the context of aging with a chronic disease.
# Appendix A

## Demographics of Study Participants

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Age</th>
<th>Year diagnosed with diabetes</th>
<th>Does the participant have a Primary Care Provider</th>
<th>Marital Status</th>
<th>Does the participant live alone</th>
<th>Employment Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruth</td>
<td>82</td>
<td>18</td>
<td>YES</td>
<td>Widowed</td>
<td>See Comments</td>
<td>Retired</td>
<td>Live in aide service</td>
</tr>
<tr>
<td>Marie</td>
<td>77</td>
<td>20</td>
<td>YES</td>
<td>Widowed</td>
<td>NO</td>
<td>Retired</td>
<td></td>
</tr>
<tr>
<td>Grace</td>
<td>65</td>
<td>22</td>
<td>YES</td>
<td>Widowed</td>
<td>YES</td>
<td>Retired</td>
<td>Family provides support</td>
</tr>
<tr>
<td>Margaret</td>
<td>68</td>
<td>38</td>
<td>YES</td>
<td>Divorced</td>
<td>YES</td>
<td>Retired</td>
<td>Aide service</td>
</tr>
<tr>
<td>Flossie</td>
<td>74</td>
<td>16</td>
<td>YES</td>
<td>Single</td>
<td>YES</td>
<td>Retired</td>
<td></td>
</tr>
<tr>
<td>Alethea</td>
<td>72</td>
<td>16</td>
<td>YES</td>
<td>Widowed</td>
<td>YES</td>
<td>Retired</td>
<td></td>
</tr>
<tr>
<td>Laela Mae</td>
<td>75</td>
<td>25</td>
<td>YES</td>
<td>Widowed</td>
<td>YES</td>
<td>Retired</td>
<td></td>
</tr>
<tr>
<td>Helen</td>
<td>72</td>
<td>10</td>
<td>YES</td>
<td>Married</td>
<td>NO</td>
<td>Retired</td>
<td></td>
</tr>
<tr>
<td>Emma</td>
<td>68</td>
<td>4</td>
<td>YES</td>
<td>Divorced</td>
<td>YES</td>
<td>Retired</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B

Raw Data
Alethea

The first level of reflection on Alethea’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with their fundamental meanings.

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“We had so much in common, it was amazing. She did everything she could to make things better.”</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>“She was a very good nurse but what made me feel better was …the person she was … easy to be with.”</td>
<td></td>
</tr>
<tr>
<td>“I was touched.”</td>
<td></td>
</tr>
<tr>
<td>“I told her how I was feeling and she came right over. All the bottled up feelings inside came out, I cried and exhaled. I felt like I was at home with a friend who understood.”</td>
<td>Making connections</td>
</tr>
<tr>
<td>“I still feel a connection.”</td>
<td></td>
</tr>
<tr>
<td>“She helped me to learn to take care of myself and understand that to a certain degree, my health is in my own hands.”</td>
<td>Transforming</td>
</tr>
<tr>
<td>“The nurse taught me how to be proactive not reactive when it comes to my health.”</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>“I don’t know how I would have managed without her.”</td>
<td></td>
</tr>
<tr>
<td>“She knew exactly what to do and she did not leave me.”</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>“She was very supportive when I was in a difficult place and didn’t have control of my situation.”</td>
<td></td>
</tr>
<tr>
<td>“She was so kind, very professional and humble, very caring I could feel her sincerity and genuine interest which meant a lot.”</td>
<td>Going beyond</td>
</tr>
<tr>
<td>“She always took that extra step to help me.”</td>
<td></td>
</tr>
</tbody>
</table>
The second level of reflection on Alethea’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

**Interpreted Thematic Statements from Ruth’s lived experience**

<table>
<thead>
<tr>
<th>Thematic Statements</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Authentic presence</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>2. Equanimity</td>
<td>Making connections</td>
</tr>
<tr>
<td>3. Reaching out</td>
<td>Transforming</td>
</tr>
<tr>
<td>4. Instilling hope</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>5. Fostering growth and self-actualization.</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>6. Finding a deeper meaning that transforms suffering.</td>
<td>Going beyond</td>
</tr>
<tr>
<td>7. Concern for the inner life world and subjective meaning of another.</td>
<td></td>
</tr>
<tr>
<td>8. Offering love and compassion</td>
<td></td>
</tr>
<tr>
<td>9. Transcending self</td>
<td></td>
</tr>
</tbody>
</table>
Ruth

The first level of reflection on Ruth’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with their fundamental meanings.

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“She don’t make me feel like I’m just some old lady, but I matter to her and she cares.”</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>“She doesn’t treat me like I’m a sick person. She showed concern about whatever mattered to me.”</td>
<td>Making connections</td>
</tr>
<tr>
<td>“She is always very respectful.”</td>
<td></td>
</tr>
<tr>
<td>“We share something.”</td>
<td>Transforming</td>
</tr>
<tr>
<td>“Our connection is personal and still professional, it’s not just business.”</td>
<td></td>
</tr>
<tr>
<td>“I know things will work out.”</td>
<td></td>
</tr>
<tr>
<td>“I trust what she says. I know she will help me with what I need.”</td>
<td></td>
</tr>
<tr>
<td>“She includes me in everything that's going on, talks with, me ask me how I want to manage things and gives me choices about what I can do.”</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>“Always helpful.”</td>
<td></td>
</tr>
<tr>
<td>“She takes her time.”</td>
<td></td>
</tr>
<tr>
<td>“Listens, shows compassion and understanding.”</td>
<td></td>
</tr>
<tr>
<td>“If it wasn’t for the nurses being so supportive, I could not live in my home.”</td>
<td></td>
</tr>
<tr>
<td>“Because of the care nurses give, I adjusted to my situation.”</td>
<td></td>
</tr>
<tr>
<td>“I feel a connection to a person, not just a professional.”</td>
<td></td>
</tr>
<tr>
<td>“I felt she had my best interest at heart.”</td>
<td></td>
</tr>
<tr>
<td>“I can trust her.”</td>
<td></td>
</tr>
<tr>
<td>“She is responsive, always following up on things.”</td>
<td></td>
</tr>
<tr>
<td>“She goes out of her way to make sure everything is correct.”</td>
<td></td>
</tr>
</tbody>
</table>
“Genuinely concerned.”

The second level of reflection on Ruth’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

**Interpreted Thematic Statements from Ruth’s lived experience**

1. Preserving human dignity and respect.
2. Authentic presence.
3. Connecting with the human spirit.
4. Transpersonal caring.
5. Finding a deeper meaning that transforms suffering.
6. Concern for the inner life world and subjective meaning of another.
7. Reaching out to another.
8. Transcending self

**Meaning**

Being viewed as a whole
Making connections.
Transforming.
Finding meaning.
Offering self with open heart
Going beyond
The first level of reflection on Emma’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with their fundamental meanings.

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“She treated me like an individual, it felt good to feel I had choices instead of always feeling helpless and out of control.”</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>“Sometimes the nurses would call me on the phone between visits, just to show concern.”</td>
<td>Making connections</td>
</tr>
<tr>
<td>“It is touching to have someone like her care.”</td>
<td>Transforming</td>
</tr>
<tr>
<td>“She would call me on the phone between visits, just to … remind me she was available.”</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>“She was open.”</td>
<td></td>
</tr>
<tr>
<td>“I had faith that things would get better.”</td>
<td></td>
</tr>
<tr>
<td>“That extra attention she gave me was a motivating force.”</td>
<td></td>
</tr>
<tr>
<td>“She was involved and showed concern this encouraged me.”</td>
<td></td>
</tr>
<tr>
<td>“Her guidance and interest in my health … that’s what made a difference in my life.”</td>
<td></td>
</tr>
<tr>
<td>“The reality of my situation is not just a life with diabetes, it’s living life every day.”</td>
<td></td>
</tr>
<tr>
<td>“Closer to the front of my mind is making my life better every day.”</td>
<td></td>
</tr>
<tr>
<td>“She helped me see other options”</td>
<td></td>
</tr>
<tr>
<td>“She was caring, would call me on the phone to ask if I was alright.”</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>“It made me feel we share something special”</td>
<td></td>
</tr>
<tr>
<td>“She went out of her way more than what I expected.”</td>
<td>Going beyond</td>
</tr>
</tbody>
</table>
The second level of reflection on Ruth’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

**Interpreted Thematic Statements from Emma’s lived experience**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preserving human dignity and respect.</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>3. Connecting with the human spirit.</td>
<td>Transforming.</td>
</tr>
<tr>
<td>5. Finding a deeper meaning that transforms suffering.</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>6. Concern for the inner life world and subjective meaning of another.</td>
<td>Going beyond</td>
</tr>
<tr>
<td>7. Reaching out to another.</td>
<td></td>
</tr>
<tr>
<td>8. Transcending self</td>
<td></td>
</tr>
</tbody>
</table>
Grace

The first level of reflection on Grace’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with the fundamental meanings.

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“She made me feel like a whole person again.”</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>“The nurse took really good care of me.”</td>
<td></td>
</tr>
<tr>
<td>“She gave me that special attention and I needed it at the time.”</td>
<td></td>
</tr>
<tr>
<td>“So respectful.”</td>
<td></td>
</tr>
<tr>
<td>“I called it a professional friendship because I feel connected to her.”</td>
<td>Making connections</td>
</tr>
<tr>
<td>“If I ever need someone to take care of me, it would be her because she cares about me.”</td>
<td></td>
</tr>
<tr>
<td>“I felt comfortable.”</td>
<td></td>
</tr>
<tr>
<td>“I could talk to her about more than just the health stuff.”</td>
<td></td>
</tr>
<tr>
<td>“The nurse showed so much compassion and concern it healed my body and spirit.”</td>
<td>Transforming</td>
</tr>
<tr>
<td>“She always took her time and was patient.”</td>
<td></td>
</tr>
<tr>
<td>“Talking to her made me feel like I could still get out and live my life.”</td>
<td></td>
</tr>
<tr>
<td>“I don’t look at myself as being sick because I can manage my illness.”</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>“She was always smiling, and pleasant, with a great sense of humor. She made me feel better.”</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>“Something stirs inside me and made me feel like a better person for having that experience.”</td>
<td></td>
</tr>
<tr>
<td>“Open to listen to what I was feeling.”</td>
<td></td>
</tr>
<tr>
<td>“When I was at my lowest point, she listened to me and treated me like I was her sister instead of a patient.”</td>
<td>Going beyond</td>
</tr>
</tbody>
</table>
The second level of reflection on Grace’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

<table>
<thead>
<tr>
<th>Interpreted Thematic Statements from Grace’s lived experience</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preserving human dignity and respect.</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>2. Authentic presence.</td>
<td>Making connections</td>
</tr>
<tr>
<td>3. Connecting with the human spirit.</td>
<td>Transforming</td>
</tr>
<tr>
<td>4. Listening</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>5. Transpersonal caring.</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>6. Finding a deeper meaning that transforms suffering.</td>
<td>Going beyond</td>
</tr>
<tr>
<td>7. Concern for the inner life world and subjective meaning of another.</td>
<td></td>
</tr>
<tr>
<td>8. Reaching out to another.</td>
<td></td>
</tr>
<tr>
<td>9. Transcending self</td>
<td></td>
</tr>
</tbody>
</table>
Flossie

The first level of reflection on Ruth’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with the fundamental meanings.

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“She was very patient and very kind. I felt good about the time we spent together, it wasn’t just the nursing.”</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>“She always treated me like we were on the same level.”</td>
<td></td>
</tr>
<tr>
<td>“…treated me like a person.”</td>
<td></td>
</tr>
<tr>
<td>“The nurse did not judge me or dismiss my feelings, she just listened.”</td>
<td>Making connections</td>
</tr>
<tr>
<td>“We could relate.”</td>
<td></td>
</tr>
<tr>
<td>“I trusted what she said.”</td>
<td></td>
</tr>
<tr>
<td>“She reassured me that I could turn my situation around and I was able to do that.”</td>
<td>Transforming</td>
</tr>
<tr>
<td>“She gave me a lot of good ideas about how to make it better and easier for me to manage.”</td>
<td></td>
</tr>
<tr>
<td>“She helped me live with my illness.”</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>“I know she doesn’t do it for the money because she gives you herself and money can’t buy that.”</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>“She shared herself.”</td>
<td></td>
</tr>
<tr>
<td>“She touched me and listened which helped to face my feelings and calm the anxiety.”</td>
<td>Going beyond</td>
</tr>
<tr>
<td>“It wasn’t just a job to her, it’s who she is, a very caring person.”</td>
<td></td>
</tr>
</tbody>
</table>
The second level of reflection on Flossie’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

<table>
<thead>
<tr>
<th>Interpreted Thematic Statements from Flossie’s lived experience</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Consciousness.</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>2. Authentic presence.</td>
<td>Making connections</td>
</tr>
<tr>
<td>3. Connecting with the human spirit.</td>
<td>Transforming</td>
</tr>
<tr>
<td>4. Listening</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>5. Transpersonal caring.</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>6. Finding a deeper meaning that transforms suffering.</td>
<td>Going beyond</td>
</tr>
<tr>
<td>7. Concern for the inner life world and subjective meaning of another.</td>
<td></td>
</tr>
<tr>
<td>8. Reaching out to another.</td>
<td></td>
</tr>
<tr>
<td>9. Transcending self</td>
<td></td>
</tr>
</tbody>
</table>
Helen

The first level of reflection on Helen’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with the fundamental meanings.

**Critical Phrases**

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“She looked beyond my disease and her job, she looked at my whole life and made</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>a difference.”</td>
<td></td>
</tr>
<tr>
<td>“I felt like she cared and was concerned.”</td>
<td></td>
</tr>
<tr>
<td>“She focused on our situation.”</td>
<td></td>
</tr>
<tr>
<td>“I felt connected to her, she understood my situation.”</td>
<td>Making connections</td>
</tr>
<tr>
<td>“She cared enough to listen.”</td>
<td></td>
</tr>
<tr>
<td>“I was confident that she would do what was best for us.”</td>
<td></td>
</tr>
<tr>
<td>“She was so compassionate. It was amazing. The last thing I expected was for</td>
<td>Transforming</td>
</tr>
<tr>
<td>her to be interested in what was going on with my husband, but she was, and</td>
<td></td>
</tr>
<tr>
<td>that made life comfortable again”</td>
<td></td>
</tr>
<tr>
<td>“She was supportive.”</td>
<td></td>
</tr>
<tr>
<td>“I felt so much better after she helped us.”</td>
<td></td>
</tr>
<tr>
<td>“Life took on a different twist, that just means we have to do things differently</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>and the nurse helped us figure that out.”</td>
<td></td>
</tr>
<tr>
<td>“I was able to open up to her and trust her judgement.”</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>“She was warm and personable.</td>
<td></td>
</tr>
<tr>
<td>“She gave us an extra piece of herself.”</td>
<td></td>
</tr>
<tr>
<td>“She went that extra mile to help me solve an overwhelming problem.”</td>
<td>Going beyond</td>
</tr>
</tbody>
</table>
The second level of reflection on Helen’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

**Interpreted Thematic Statements from Helen’s lived experience**

1. Consciousness.
2. Authentic presence.
3. Connecting with the human spirit.
4. Listening
5. Transpersonal caring.
6. Finding a deeper meaning that transforms suffering.
7. Concern for the inner life world and subjective meaning of another.
8. Reaching out to another.
9. Transcending self
10. Offering love and compassion.

**Meaning**

- Being viewed as a whole
- Making connections
- Transforming
- Finding meaning
- Offering self with open heart
- Going beyond
Marie

The first level of reflection on Marie’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with the fundamental meanings.

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“She guided me through the situation in a caring manner.”</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>“She allowed me to say how I felt.”</td>
<td></td>
</tr>
<tr>
<td>“The nurse did not judge me or dismiss my feelings, she just listened.”</td>
<td></td>
</tr>
<tr>
<td>“She paid attention to how I was feeling.”</td>
<td></td>
</tr>
<tr>
<td>“She listened to me.”</td>
<td></td>
</tr>
<tr>
<td>We got to know each other, we connected.”</td>
<td>Making connections</td>
</tr>
<tr>
<td>“She was right there with me.”</td>
<td></td>
</tr>
<tr>
<td>“Her encouragement and positive attitude made me believe I could do it.”</td>
<td>Transforming</td>
</tr>
<tr>
<td>“I felt encouraged to continue on the right path to preserve my health.”</td>
<td></td>
</tr>
<tr>
<td>“Always took her time, and never rushed.”</td>
<td></td>
</tr>
<tr>
<td>“I feel grateful that I can still be healthy if I care for myself. I owe that to her, my health.”</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>“She was patient and supportive.”</td>
<td></td>
</tr>
<tr>
<td>“Compassionate.”</td>
<td></td>
</tr>
<tr>
<td>“She was very caring and involved; She made me feel like I was her only patient.”</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>“Her words were reassuring; having her with me gave me confidence.”</td>
<td></td>
</tr>
<tr>
<td>“She put her hand on my shoulder, and told me to relax and said she would visit every morning to make sure I got my insulin.”</td>
<td>Going beyond</td>
</tr>
<tr>
<td>“She was so personal and warm, more than what I imagined.”</td>
<td></td>
</tr>
</tbody>
</table>
The second level of reflection on Marie’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

<table>
<thead>
<tr>
<th>Interpreted Thematic Statements from Marie’s lived experience</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preserving human dignity and respect.</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>2. Authentic presence.</td>
<td>Making connections</td>
</tr>
<tr>
<td>3. Connecting with the human spirit.</td>
<td>Transforming</td>
</tr>
<tr>
<td>4. Fostering growth and self-actualization.</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>5. Transpersonal caring.</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>7. Concern for the inner life world and subjective meaning of another.</td>
<td></td>
</tr>
<tr>
<td>8. Reaching out to another.</td>
<td></td>
</tr>
<tr>
<td>9. Transcending self</td>
<td></td>
</tr>
</tbody>
</table>
Laela

The first level of reflection on Laela’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with the fundamental meanings.

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“She listened to me talk about my family and what was happening in my life. “</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>&quot;The nurse was concerned with, everything that affected my health.”</td>
<td></td>
</tr>
<tr>
<td>“She takes her time”</td>
<td></td>
</tr>
<tr>
<td>“I feel like she is wrapping my spirit too.”</td>
<td></td>
</tr>
<tr>
<td>“She was patient. Every day, she was right there, we would take another step.</td>
<td>Making connections</td>
</tr>
<tr>
<td>We got to know each other, we connected.”</td>
<td></td>
</tr>
<tr>
<td>“She made me feel at ease about my health situation.”</td>
<td></td>
</tr>
<tr>
<td>“Her patience and caring helped me feel better.”</td>
<td>Transforming</td>
</tr>
<tr>
<td>“She connected me to the services I needed to be safe living at home”</td>
<td></td>
</tr>
<tr>
<td>“She was very helpful with learning to manage my diabetes.”</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>“Because of her support, I can live past the illness.”</td>
<td></td>
</tr>
<tr>
<td>“She made a difference, I don’t feel isolated anymore.”</td>
<td></td>
</tr>
<tr>
<td>“She put her hand on my shoulder, and told me to relax.”</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>“I felt like she cared about what happened to me.”</td>
<td></td>
</tr>
<tr>
<td>“She showed an interest in doing her best for me, to make sure that I was ok.”</td>
<td>Going beyond</td>
</tr>
</tbody>
</table>
The second level of reflection on Laela’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

**Interpreted Thematic Statements from Laela’s lived experience**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Authentic presence.</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>2. Connecting with the human spirit.</td>
<td>Making connections</td>
</tr>
<tr>
<td>3. Transpersonal caring.</td>
<td>Transforming</td>
</tr>
<tr>
<td>4. Finding a deeper meaning that transforms suffering.</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>5. Concern for the inner life world and subjective meaning of another.</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>6. Reaching out to another.</td>
<td>Going beyond</td>
</tr>
<tr>
<td>7. Transcending self</td>
<td></td>
</tr>
<tr>
<td>8. Offering love and compassion.</td>
<td></td>
</tr>
</tbody>
</table>
Margaret

The first level of reflection on Margaret’s descriptions of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following critical statements associated with the fundamental meanings.

<table>
<thead>
<tr>
<th>Critical Phrases</th>
<th>Fundamental Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>“She is someone I can call on.”</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>“I know I can put my life in her hands because she cares about me.”</td>
<td></td>
</tr>
<tr>
<td>“That’s my special friend.”</td>
<td></td>
</tr>
<tr>
<td>“Always shows respect for me as a person”</td>
<td></td>
</tr>
<tr>
<td>“We have a special relationship, more of a friendship.”</td>
<td>Making connections</td>
</tr>
<tr>
<td>“She is very understanding, and respectful.”</td>
<td></td>
</tr>
<tr>
<td>“She treats me like an equal.”</td>
<td></td>
</tr>
<tr>
<td>“It felt like my family was with me, she took time to share and spend a personal moment with me. I started baking again; I thought I couldn’t do that anymore.”</td>
<td>Transforming</td>
</tr>
<tr>
<td>“She cares for me, that helps me to live with my situation.”</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>“She takes time and understands what helps me function better.”</td>
<td></td>
</tr>
<tr>
<td>“I always look forward to her visits.”</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>“That’s my friend.”</td>
<td></td>
</tr>
<tr>
<td>“When I’m a little down, she perks me up.”</td>
<td></td>
</tr>
<tr>
<td>“It’s like I do have family close by.”</td>
<td></td>
</tr>
<tr>
<td>“I know she is there for me and I can call her for anything.”</td>
<td>Going beyond</td>
</tr>
</tbody>
</table>
The second level of reflection on Margaret’s experience of aging with diabetes and her perceptions of caring-healing with nurses that visited in her home revealed the following thematic statements and their associated meanings.

**Interpreted Thematic Statements from Margaret’s lived experience**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preserving human dignity and respect.</td>
<td>Being viewed as a whole</td>
</tr>
<tr>
<td>2. Authentic presence.</td>
<td>Making connections</td>
</tr>
<tr>
<td>3. Connecting with the human spirit.</td>
<td>Transforming</td>
</tr>
<tr>
<td>4. Transpersonal caring.</td>
<td>Finding meaning</td>
</tr>
<tr>
<td>5. Making meaning of the human experience.</td>
<td>Offering self with open heart</td>
</tr>
<tr>
<td>6. Concern for the inner life world and subjective meaning of another.</td>
<td>Going beyond</td>
</tr>
<tr>
<td>7. Reaching out to another.</td>
<td></td>
</tr>
<tr>
<td>8. Transcending self</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

Study Documents
DATE: October 29, 2014
TO: Deidra Brown, MSN, NP
FROM: Hunter College (CUNY) HRPP Office
PROJECT TITLE: [597217-1] The Lived Experiences of Aging Diabetic Black Women’s Caring-Healing Relationship with the Nurse
SUBMISSION TYPE: New Project
ACTION: APPROVED
APPROVAL DATE: October 27, 2014
EXPIRATION DATE: October 26, 2015
RISK LEVEL: Minimal Risk
REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review category # 6,7

Thank you for your submission of New Project materials for this project. The University Integrated IRB has APPROVED your research. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

Please remember that informed consent is a process beginning with a description of the project and assurance of the participant's understanding, followed by a signed consent form(s). Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

The University Integrated IRB has determined that a waiver of documentation of consent has been approved for the screening procedures for this research, under 45 CFR 46.117.

Please note that any modifications/changes to the approved materials must be approved by this IRB prior to implementation. Please use the appropriate modification submission form for this request.

All UNANTICIPATED PROBLEMS (UPS) involving risks to subjects or others, NON-COMPLIANCE issues, and SUBJECT COMPLAINTS must be reported promptly to this office. All sponsor reporting requirements must also be followed. Please use the appropriate submission form for this report.

This research must receive continuing review and final IRB approval before the expiration date of October 26, 2015. Your documentation for continuing review must be received with sufficient time for the IRB to conduct its review and obtain final IRB approval by that expiration date. Please use the appropriate continuation submission forms for this procedure. PLEASE NOTE: The regulations do not allow for any grace period or extension of approvals.

If you have any questions, please contact Sarah Leon at (212) 650-3053 or bleon@hunter.cuny.edu. Please include your project title and reference number in all correspondence with this committee.
ORAL OR INTERNET BASED INFORMED CONSENT SCRIPT

Title of Research Study: The Lived Experience of Aging Black Women with Diabetes
Nurse-Person Relationship

Principal Investigator: Deidra G. Brown, RN, MSN, NP
Doctor of Philosophy in Nursing Student

Thank you for your interest in this study. You are being asked to participate in a research study because you are a Black woman between the age of 65 and 85 years, diagnosed with diabetes for at least one year and you received visiting nurse service to help manage your diabetes. The purpose of the study is to identify and better understand the unique experiences of older Black women aging with diabetes that were visited at home by a nurse. If you agree to participate, we will ask you to do the following:

• Give written consent agreeing to participate in the study and consent to being audio taped.
• Participate in two interviews that take place at a time and location you agree upon, your home or a private room at the First Reformed Church of Jamaica.
• The first interview will last about 60 minutes Deidra will ask questions about what it is like for you getting older with diabetes and your thoughts and feelings about the nurse that visited you.
• Also some questions will be asked about you, such as your age and how well you get around.
• A few weeks after the interview, Deidra will contact you for a second interview that will last about 30 to 45 minutes to clarify what you told her.
• The interviews will be tape recorder to make sure what you say is accurately captured.

Sometimes when people reflect on issues like getting older and their health, they feel emotions like sadness or anxiety. If you would like to talk with someone about your feelings, you can call the mobile crisis team at 1-800-543-3638 (LIFENET) 24 hours a day. You can choose to not answer any particular question. You may also stop the interview process at any time.

We will make our best efforts to maintain confidentiality of any information that is collected during this research study, and that can identify you. We will disclose this information only with your permission or as required by law.

We will protect your confidentiality by allowing only the researcher and her faculty advisor to listen to the tapes. The tapes will use identifying codes. Your name will not appear on the transcripts. Tapes will be destroyed after interviews are transcribed. No personal identifiers can be linked to the data. All materials will be safeguarded in encrypted files on a computer to which only the researcher and her faculty advisor have access. The data will be stored securely in the
faculty advisors office for a minimum of three years. After that, all materials may be destroyed. As long as the data exists it will be kept secured. The information will be used to produce a paper for a graduate research project.

The researcher is mandated to report to the proper authorities any indications that you are in imminent danger of harming yourself or others.

The research team, authorized CUNY staff, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.

Your participation in this research is voluntary. If you have any questions, you can contact Deidra G. Brown at dbrown2@gc.cuny.edu. If you have any questions about your rights as a research participant or if you would like to talk to someone other than the researchers, you can contact CUNY Research Compliance Administrator at 646-664-8918.

Potential subjects will be given sufficient time to consider whether or not to participate in the research. After allowing the potential subject sufficient time, PI will solicit any questions the potential subject may have and answers them. Then the PI will obtain verbal consent to participate in the research by directly ask the potential subject if she agrees to participate in the study. Finally, the PI will document on a data sheet: (1) that the oral informed consent script was read; (2) the potential subject was offered the opportunity to ask questions; and (3) they agreed or declined to participate in the study; (4) the date oral consent was obtained.

Potential subjects that agree to participate in the study will be asked the following screening questions:

“In order to be sure that you can participate in the study, I am going to ask you some questions, if it is alright with you. How old are you? With what racial/ethnic group do you identify yourself? How long have you had diabetes? Have you ever had a nurse visit you at home because of your diabetes?”
Recruitment Advertising

Hunter College School of Nursing and the CUNY Graduate Center

The lived Experience of Aging Diabetic Black Women’s Caring-Healing Relationship with the Nurse

Participants are needed for a doctoral nursing research study to understand the unique experiences of older Black women aging with diabetes that were visited at home by a nurse.

In order to participate in the study, you must be:

- Between 65 and 85 years of age
- Black woman
- Diagnosed with diabetes for at least one year
- Available for a one hour interview and then a 45 minute post-follow-up interview.

Why Participate??

You may discover and better understand your experience with diabetes self-management.

All participants will have the opportunity to enter in a raffle for a $50.00 VISA gift card.

Participation is voluntary and you may withdraw at any time without consequences.

For more information please contact:

Deidra G. Brown, RN
Doctor of Nursing Science student at the Graduate Center,
City University of New York
Email: dbrown2@gc.cuny.edu
Interview Guided Research Questions

1. Tell me about your experience living with diabetes at this time in your life, what is it like for you? What are the major challenges or issues you face?

2. Why did you start receiving home care services? Probe: tell me about it. How would you describe the care you received? Was there anything in particular that helped?

3. Describe your experience with the nurse. Probe: What was that experience like for you?

4. What aspects of your relationship with the nurse were most meaningful and important to you?

5. How did this relationship with the nurse impact your life?

6. What can nurses do to help you better manage aging with diabetes? Include what is helpful and not helpful.

7. Is there anything else you would like to share with me?
September 9, 2014

To Whom It May Concern:

I am aware that Deidra G. Brown is conducting a research study. The researcher has no affiliation with this agency. This study focuses on The Lived Experience of Aging Diabetic Black Women's Caring-Healing Relationship with the Nurse. Deidra Brown has shared with me the details of her project.

I give her permission to conduct her study at our Church. First Reformed Church of Jamaica requests the identifiers of its clients be kept completely confidential in the research results.

Sincerely,

Mark S. Kellar

Rev. Mark S. Kellar, Pastor
CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of Research Study: The Lived Experience of Aging Diabetic Black Women’s Caring-Healing Relationship with the Nurse

Principal Investigator: Deidra G. Brown, RN, MSN, NP
Doctor of Philosophy in Nursing Student

Faculty Advisor: Donna M. Nickitas, PhD, RN, NEA-BC, CNE, FNAP, FAAN
Professor, Executive Officer Doctor of Philosophy in Nursing

Hunter College, City University of New York
Hunter-Bellevue School of Nursing

You are being asked to participate in a research study because you are a Black woman between the age of 65 and 85 years, diagnosed with diabetes for at least one year and you received visiting nurse service to help manage your diabetes.

Purpose:
The purpose of this research study is to better understand Black woman living and getting older with diabetes. The study will also explore the experience Black women have with a visiting nurse.

Procedures:
If you volunteer to participate in this research study, we will ask you to do the following:

- Give written consent agreeing to participate in the study and consent to being audio taped.
- Participate in two interviews that take place at a time and location you agree upon, your home or a private room at the First Reformed Church of Jamaica.
- The first interview will last about 60 minutes Deidra will ask questions about what it is like for you getting older with diabetes and your thoughts and feelings about the nurse that visited you.
- Also some questions will be asked about you, such as your age and how well you get around.
- A few weeks after the interview, Deidra will contact you for a second interview that will last about 30 to 45 minutes to clarify what you told her.
- The interviews will be tape recorder to make sure what you say is accurately captured.
- You may review, edit and/or erase the recording.
- You may stop recording at any time.
- You will not be able to participate in the study if you refuse to allow audio-recording of your interview.
- It is estimated that eight to twelve people will participate in this study.
**Time Commitment:**
Your participation in this research study is expected to include a one hour initial face-to-face interview, and a 30 to 45 minute follow-up face-to-face interview. The follow-up interview will take place approximately two to three weeks after the initial interview.

**Potential Risks or Discomforts:**
Sometimes when people reflect on issues like getting older and their health, they feel emotions like sadness or anxiety. If you would like to talk with someone about your feelings, you can call the mobile crisis team at 1-800-543-3638 (LIFENET) 24 hours a day. You can choose to not answer any particular question. You may also stop the interview process at any time.

**Potential Benefits:**
There are no direct benefits. However, a benefit to participating will be in knowing that you helped nurses learn how to help Black women aging with diabetes better address their health in a more effective way.

**Payment for Participation:**
Should you choose to participate in the study; you will be eligible to participate in a raffle for a $50.00 VISA gift card. All participants will be allowed to participate in the raffle regardless of whether they complete the entire interview or decide to withdraw from the study. The raffle winner will be selected and receive payment after the completion of the interviews.

**Confidentiality:**
We will make our best efforts to maintain confidentiality of any information that is collected during this research study, and that can identify you. We will disclose this information only with your permission or as required by law.

We will protect your confidentiality by allowing only the researcher and her faculty advisor to listen to the tapes. The tapes will use identifying codes. Your name will not appear on the transcripts. Tapes will be destroyed after interviews are transcribed. No personal identifiers can be linked to the data. All materials will be safeguarded in encrypted files on a computer to which only the researcher and her faculty advisor have access. The data will be stored securely in the faculty advisor's office for a minimum of three years. After that, all materials may be destroyed. As long as the data exists it will be kept secure. The information will be used to produce a paper for a graduate research project.

The researcher is mandated to report to the proper authorities any indications that you are in imminent danger of harming yourself or others.

The research team, authorized CUNY staff, and government agencies that oversee this type of research may have access to research data and records in order to monitor the research. Research records provided to authorized, non-CUNY individuals will not contain identifiable information about you. Publications and/or presentations that result from this study will not identify you by name.
Participants' Rights:

- Your participation in this research study is entirely voluntary. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled.

- You can decide to withdraw your consent and stop participating in the research at any time, without any penalty.

Questions, Comments or Concerns:
If you have any questions, comments or concerns about the research, you can talk to one of the following researchers: Deidra G. Brown, RN, MSN, NP at dbrown2@gc.cuny.edu or Donna M. Nickitas at dnickitas@hunter.cuny.edu.
If you have questions about your rights as a research participant, or you have comments or concerns that you would like to discuss with someone other than the researchers, please call the CUNY Research Compliance Administrator at 646-664-8918. Alternately, you can write to:

CUNY Office of the Vice Chancellor for Research
Attn: Research Compliance Administrator
205 East 42nd Street
New York, NY 10017

Agreement to be audio taped:
Do you agree to have you interview audio taped? Please check yes or no.

_____ Yes  _____ No

Signature of Participant:
If you agree to participate in this research study, please sign and date below. You will be given a copy of this consent form to keep.

Printed Name of Participant

Signature of Participant

Date

Signature of Individual Obtaining Consent

Printed Name of Individual Obtaining Consent

Signature of Individual Obtaining Consent

Date
References


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[www.aoa.gov/Aging_Statistics/Profile/2011/docs](http://www.aoa.gov/Aging_Statistics/Profile/2011/docs)


